STATEWIDE HEALTHCARE INNOVATION PLAN

OPERATIONAL PLAN – AWARD YEAR 3

IDAHO DEPARTMENT OF HEALTH AND WELFARE
OFFICE OF HEALTHCARE POLICY INITIATIVES
REVISION 1.1

DECEMBER 1, 2016

Statewide Healthcare Innovation Plan (SHIP) is supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

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A.Executive Summary

A.1. Summary of Idaho's Model Test

Idaho is transforming its healthcare system though a shared vision of delivering patient-centered, effective, and coordinated primary care services through a patient-centered medical home (PCMH) model – the foundation for primary care delivery. By February 2017, 110 primary care clinics will be part of Idaho's Statewide Healthcare Innovation Plan (SHIP) model.

Our model is built around the patient. We envision a healthcare system where Idahoans can get the care they need, as close to home as possible, through services that are integrated and coordinated across the Medical-Health Neighborhood. The design of this vision continues to be led by a partnership between healthcare professionals, payers, advocates, and State leadership, drawing from the collective knowledge and experience of providers and other stakeholders to implement our ambitious plan. Our new care model is supported and incentivized by value-based payments that emphasize outcomes and value instead of volume and, in doing so, improves health outcomes while effectively controlling costs.

Idaho's vision is rooted in the knowledge that quality healthcare is not possible without dedicated, skilled healthcare professionals. Our SHIP model provides supports at every level for clinics as they transform to the PCMH model. Public Health Districts (PHDs) and the PCMH transformation vendor provide resources and technical assistance to clinics throughout the transformation. Clinics also receive reimbursements to assist with the offset of administrative costs required to establish a PCMH model. Seven Regional Collaboratives (RCs) are supporting clinics by working to improve the coordination of care within the Medical-Health Neighborhood and identifying and sharing best practices for successful care coordination.

The RCs and PHDs also play an important role in fulfilling our vision of improved population health. As the RCs finalize their organizing activities and become more operational, they will use regional data from community health assessments and the SHIP statewide data analytics vendor to identify unmet needs and, working with PHDs and the Idaho Healthcare Coalition (IHC), support local population health improvement initiatives.

The IHC remains at the helm of our State's transformation and was reaffirmed in 2016 through executive order as the public-private leadership of this initiative. Of most importance is the IHC's role in performance monitoring of Idaho's seven goals that are the pathway for the State to fully realize all aspects of our vision. A summary of our success to date is best understood by examining the progress of each goal.

Award Year 2 (AY2) Progress and AY3 Objectives by Goal

Goal 1: Transform primary care clinics across the State into PCMHs.

Progress toward the goal of 165 primary care clinics transforming to the PCMH model by 2019 is on track with 55 clinics advancing toward the PCMH model in AY2 SHIP Cohort One.

Idaho has effectively met its success measures of providing supports and technical assistance to SHIP Cohort One clinics as they transform to the PCMH model. The PHD SHIP staff, PCMH transformation vendor, and the Idaho Department of Health and Welfare (IDHW) SHIP Team have assisted clinics with:

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(1) developing individualized Transformation Plans to identify clinic-specific goals, (2) establishing mentor relationships between more experienced and less experienced clinics, and (3) connecting clinics with the PCMH transformation vendor, PHD SHIP team, and IDHW SHIP team through a web portal to share information, schedule technical assistance, and track clinic-specific progress on their Transformation Plans.

In AY2, 81 clinics submitted applications to participate in SHIP Cohort Two, of which 55 will be selected to participate. Based on lessons learned in AY1, Idaho streamlined the process and extended the timeframes for application to Cohort 2. Between SHIP Cohorts One and Two, a total of 110 clinics will be participating in SHIP as of February 2017. These 110 clinics are anticipated to include approximately 1,100 participating providers and 550,000 enrolled Idahoans, representing significant progress toward Idaho's goal of 1,650 participating providers and 825,000 enrolled Idahoans by the end of 2019.

The AY3 objectives under Goal 1 are to:

- Continue to support clinics in SHIP Cohort One.
- Enroll 55 new primary care clinics into SHIP Cohort Two.
- Distribute financial reimbursements to SHIP Cohort Two clinics and monitor fraud/abuse protections.
- Provide technical assistance to SHIP Cohort Two clinics.
- Recruit clinics for SHIP Cohort Three (starting in AY4).

Goal 2: Improve care coordination through the use of electronic health records (EHRs) and health data connections among PCMHs and across the Medical-Health Neighborhood.

Idaho has begun laying the foundational systems needed to improve care coordination through data sharing. All 55 SHIP Cohort One clinics have EHRs that support health information exchange (HIE) connectivity. Idaho has also made significant strides in connecting SHIP cohort clinics to the HIE and sharing/receiving HIE transactions for care coordination.

Idaho incentivizes connection to the State's HIE, the Idaho Health Data Exchange (IHDE), by covering several fees normally associated with a clinic's connection to the HIE. In AY3, Idaho plans to continue using Model Test grant funds to cover the one-time EHR interface connection fee, to aid in reducing any barriers that fees may pose to a clinic's connection to IHDE. In addition, IDHW is exploring options to expand financial support by leveraging HITECH funding.

In AY2, Idaho's Medicaid program released a tiered payment structure that provides further incentives for clinics to connect to IHDE. Through this structure, clinics receive a higher per member per month (PMPM) payment for achieving view access to IHDE through the clinical portal. Clinics can achieve an even higher PMPM by establishing a bi-directional connection to IHDE. Moving forward, these payment enhancements through Medicaid will continue to motivate, support, and sustain provider investments in connecting to IHDE.

Progress has also been made toward increasing hospital connections to IHDE in order to achieve the goal of 21 hospitals connected by the end of AY4. By the end of AY3, at least three additional hospitals are expected to connect to IHDE, bringing the total number of hospitals to 11 representing 2,133 beds.

Idaho is also in the process of updating its statewide health information technology (HIT) plan.

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This update will involve consolidating previously disparate HIT plans, including the SHIP HIT Plan (presented in the 2015 Operational Plan), into a unified strategy that sets five-year targets for HIT transformation in the State. This alignment between SHIP HIT efforts and the Statewide HIT plan will benefit the advancement of Goal 2 activities in AY3.

The AY3 objectives under Goal 2 are to:

- Complete connections, evaluate, and enhance Cohort One connections to IHDE.
- Connect 55 Cohort Two clinics to IHDE.
- Training clinics on how to access and leverage the State HIE technology solution.
- Connect additional hospitals to IHDE.
- Continue to align SHIP HIT activities with the Statewide HIT plan.

Goal 3: Establish seven RCs to support the integration of each PCMH with the broader Medical-Health Neighborhood.

In AY2, Idaho established seven RCs, each with an executive team that focused on building RC membership and developing strategic plans. The strategic plans developed in AY2 were critical in helping each RC define its role in Idaho's healthcare system transformation with an eye toward sustainability. The RC membership varies in each region from 8 to 25 members with most RCs including local SHIP Cohort One clinics as members.

Idaho's PHD SHIP staff play a major role in supporting PCMH transformation at the regional level. In AY2, the PCMH transformation vendor provided training to PHD SHIP Quality Improvement Specialists in their role supporting clinics. Building PHD staff capacity helps lay the foundation for on-the-ground sustainable supports for existing and future clinics. The training consisted of self-study materials, webinars, learning collaboratives, and monthly coaching sessions.

PHD SHIP staff, leveraging regional resources and expertise, are working with local providers and community-based organizations to review regional health needs assessments to gauge the health of the community against clinical quality measures (CQMs) and to identify gaps in population health. With support from the IHC, RCs will implement or support regional quality improvement and wellness initiatives in AY3.

The AY3 objectives under Goal 3 are to:

- Implement strategic plans for each RC which address sustainability planning and using analytic solution outputs.
- Implement evaluation plans to ensure RCs provide guidance on regional quality improvement and Medical-Health Neighborhood integration.
- Identify and address gaps in the Medical-Health Neighborhood in each region.
- PHD staff will communicate with SHIP cohort clinics regarding the supports available from RCs.
- Continue health initiatives focused on improving population health.
- Continue creating a Sustainability Plan.

Goal 4: Improve rural patient access to PCMHs by developing Virtual PCMHs.

In AY2, Idaho began laying the groundwork to achieve the goal of creating 50 Virtual PCMHs by the end of AY4. Virtual PCMH requirements, standards, and the designation process were established and approved by the IHC. Contractors were procured to develop curricula and provide training for

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community health workers (CHWs) and community health emergency medical services (CHEMS) personnel. Additionally, marketing and educational activities were developed to promote use and training of CHWs and recruit candidates for CHW roles. Likewise, outreach and education was provided to emergency medical service agencies on CHEMS, and a mentoring program for CHEMS was established for those interested in participating in the model. Idaho aims to establish 13 CHEMS programs throughout the State and train 125[1] CHWs by the end of AY4.

Idaho completed two major milestones in AY2 that are critical to advancing the telehealth component of the Virtual PCMH. Early in AY2, Idaho developed a telehealth expansion and implementation plan and selected a telehealth contractor to help expand telehealth technology in Virtual PCMHs, including training and technical assistance. In AY3, Idaho will finalize the telehealth application for PCMHs and will begin accepting applications from SHIP cohort PCMHs that want to receive technical assistance in incorporating telehealth in their clinics.

The AY3 objectives under Goal 4 are to:

- Continue to recruit clinics to become Virtual PCMHs[2]
- Begin reimbursement payments for Virtual PCMHs that meet criteria.
- Continue recruiting and engaging CHEMS[3].
- Continue recruiting and engaging CHWs[4].
- Amend contract to continue CHW training and expand offerings as needed.
- Develop and implement new telehealth programs in SHIP cohort clinics[5].

Goal 5: Build a statewide data analytics system that tracks progress on selected quality measures at the individual patient level, regional level and statewide.

In AY2, Idaho stakeholders worked collaboratively to operationalize the design for Goal 5 and establish critical infrastructure for data reporting and analytics. Under the guidance of the HIT Workgroup and the IHC, Idaho's CQMs (selected during Idaho's State Innovation Model (SIM) planning) were reviewed and modifications were made to operationalize the measures. A schedule for CQM reporting was also developed. The schedule phases-in the reporting of clinical measures to allow sufficient time for clinics to develop data collection processes and resolve connection issues.

Idaho successfully procured a data analytics contractor that will provide analytics services and evaluate outcomes for the CQMs. With the assistance of the contractor, Idaho made significant strides in AY2 toward defining and operationalizing the reporting pathway for CQMs from cohort clinics to IHDE and then ultimately to the data analytics contractor for analytics and the production of reports.

The AY3 objectives under Goal 5 are to:

- Operationalize data reporting on AY3 CQMs.

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[1] Idaho reduced its original goal of training 200 CHWs to 125 due to limited funding sources to pay for CHWs.
[2] AY2 target has been set at 18 (and will be designated around end of March 2017) and the AY3 target set at 18 to be designated before the state of AY4.
[3] AY3 target is set at 15.
[4] AY3 target is set at 50.
[5] AY3 target is anticipated to establish 12 programs.

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- Build the data analytics and reporting infrastructure.
- Define baselines for the initial four CQMs.
- Provide technical assistance to support 110 SHIP clinics reporting data on four CQMs and 55 clinics reporting on an additional six measures.
- Provide access to CQM reports to RCs and other stakeholders.
- Develop team/workgroup to address technical and quality issues related to CQMs.

Goal 6: Align payment mechanisms across payers to transform payment methodology from volume to value.

Idaho continues to effectively drive payment reform through collaboration across public and private payers. In AY2, an Idaho alternative payment model framework was developed by the Multi-Payer Workgroup and IHC based on the Health Care Payment Learning and Action Network Model.[6] The framework delineates a continuum that advances from fee-for-service (FFS) to value-based payment strategies, and reflects the different payment methodologies in the Idaho marketplace.

Data was collected from Medicaid, Medicare, and commercial payers on payments made across the payment methodologies in Idaho's framework using a common reporting template developed in collaboration with payers. Payers reported the following data for calendar year 2015 across all lines of business:

- Percentage of beneficiaries per payment structure (e.g. FFS, shared savings, etc.).
- Total percentage of payments (paid or accrued) to providers per payment structure.
- Total payments paid to providers.

In AY3, Idaho's payers will continue to shift their payments for health care services from those that incentivize volume of care to models that incentivize the value of care. To measure the State's progress toward paying for value through alternatives to FFS payment models, in AY3 Idaho will report to the IHC the results of AY2 payer data[7] and collect the second year of annual data from commercial payers, Medicare, and Medicaid.

The AY3 objectives under Goal 6 are to:
- Collect data from payers to track progress toward paying for value.
- Analyze data and report progress to IHC.

Goal 7: Reduce overall healthcare costs.

By transforming the way healthcare is delivered, Idaho expects to lower the overall cost of care for Idahoans. In AY2, a financial analysis was conducted to project the anticipated cost savings and return

[6] The Health Care Payment Learning and Action Network was established by the U.S. Health & Human Services Department to create a forum for public-private entities to exchange best practices regarding how to transition to alternative payment models that emphasize value. More information can be found at: https://innovation.cms.gov/initiatives/Health-Care-Payment-Learning-and-Action-Network/

[7] After signing a non-disclosure agreement with Mercer, Idaho's program management and financial analysis vendor, payers submitted aggregate data to Mercer. Mercer collected data from payers, instead of IDHW or another Idaho entity, in part to ensure the privacy of payer data. All payer data is aggregated prior to reporting so that no individual payer's data is identifiable to IDHW, the IHC, or CMMI.

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on investment (ROI) of Idaho's SHIP. The analysis found that over the three year testing period of the model, Idaho can expect to see a projected total savings of $89.56 million, after factoring in payment (both Medicaid and commercial payers) to primary care providers to coordinate care and adhere to the PCMH model. Net savings are $34.1 million for Medicaid, $32.0 million for commercial payers, and $23.5 million for Medicare. Projected ROI for Medicare and Medicaid populations combined is 44% for the three years. The projected ROI for all populations combined is 124% for the same time period.

The AY3 objective under Goal 7 is to:

- Collect data from payers needed to conduct the cost savings analysis and return on investment.

A.2. End State Vision

In 2013, Idaho's diverse group of statewide stakeholders and the Idaho Department of Health and Welfare set forth the vision for the State's healthcare system. The vision statement was drafted by the IHC.

> "An innovative, ambitious, forward-thinking plan for the State of Idaho — will be centered on building a robust primary care system statewide through the delivery of services in a patient centered medical home (PCMH) model of patient-centered, team-based, coordinated care. Care will be integrated and coordinated across all healthcare services in the state, yielding cost efficiencies and improved population health. Idaho will achieve its vision of system-wide reform that, with the commitment of commercial payers and Medicaid, will move Idaho from a system that rewards the volume of services (through predominantly fee for service (FFS) arrangements) to a system that rewards the value of services (through quality incentives, shared savings, etc.). Payment methods will incentivize providers to spread best practices of clinical care and achieve improved health outcomes for patients and communities. Key to the success of the model is the development of the Idaho Healthcare Coalition (IHC) and its Regional Collaboratives (RCs) which will support clinics at every level throughout and after the transformation to a PCMH. The newly formed IHC will oversee the development of this performance-driven model. Together, the IHC and RCs will support the PCMHs in activities to transform and improve the system, including collecting data required to monitor and establish performance targets, providing regional and PCMH-level performance feedback, identifying and spreading evidence-based clinical practice, and providing on-going resources and support to achieve the Triple Aim of improved health outcomes, improved quality and patient experience of care, and lower costs of care for all Idahoans."

Since then, Idaho has been making steady progress toward achieving this vision for the State's healthcare system.

At the end of the Model Test period in 2019:

1. A minimum of 165 primary care clinics around the State will be providing patient-centered, team-based, coordinated care through the PCMH model. Care will be integrated and coordinated across all medical and health services in the Medical-Health Neighborhood and physical and behavioral health, in particular, will be better integrated at the local level; both of which will contribute significantly to community and statewide improved population health.

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2. The RCs and PHDs will be providing on-the-ground support for transformation and improved population health initiatives as described in the PHD's mission and goals and each RC's strategic plan.

3. The IHC will continue to guide, oversee, and monitor the expansion and impact of Idaho's performance-driven model after the SIM Test is completed. Working with the RCs, PHDs, and IDHW, the IHC will continue to offer support of PCMHs in activities that will expand and cement Idaho's system transformation.

4. The advancement of alternatives to FFS arrangements will continue to reflect the same steady progress that will have been demonstrated during the Model Test grant period. The IHC will work with payers through the Multi-Payer Workgroup and other avenues to continue to accelerate the transition to alternatives to FFS payment; this will include the introduction of CQMs available at the clinic, county, region and state level as well as user stories (e.g. patient vignettes) illustrating the effectiveness and return on investment PCMH can have. A process for monitoring progress will have been developed in collaboration with payers to replace the independent data collection and financial analysis available during the Model Test Period.

5. At least 165 clinics will be reporting on a core group of clinic based CQMs that span across multiple payers. This information will be used by payers to inform value-based payment approaches and reward quality care. Information will be used to identify regional opportunities for clinical care best practice and local and statewide health areas needing targeted population health improvements. As part of Goal 1, Idaho will be exploring with healthcare professionals and other stakeholders ways to share this information in order to empower patient choice and spread the highest quality healthcare as the standard of care. In addition, all clinics will be using EHRs as care coordination tools, and will be sharing and receiving information from the IHDE, as will numerous hospitals around the state.

The coordination of all these activities will be challenging with the loss of SIM grant funds to support key positions at IDHW. Recognizing the important role of managing and monitoring system change, IDHW will identify ways to continue to dedicate resources to this task at the conclusion of the Model Test. Options may include a request to the state legislature for funds to support continuation of key positions or other mechanisms identified by the IHC.

A.3. Updated Driver Diagram

Figure 1 shows Idaho's updated master driver diagram. Idaho's goal is to achieve the Triple Aim of (1) improving health outcomes, (2) improving quality and patient experience of care, and (3) reducing the cost of healthcare in the state. The primary drivers of system transformation are the seven goals of Idaho's SHIP Model, discussed in greater detail in Section B of this Operational Plan. The secondary drivers of system transformation are the outcomes associated with each goal, which will be the areas of focused activity on the part of payers, providers, patients, and others.

Figures 2–5 show the breakdown of each of the four primary drivers, and have been updated to include the revised metrics for each driver that will be monitored and reported to track the model's progress. Accountability targets for each metric are also shown, which will serve as guideposts for evaluating the Model's performance during implementation. HIT activities are integral to success in achieving SHIP metrics and additional details can be found in the master timeline and Section B of this Operational Plan.

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The Driver Diagram has been updated as follows:

- Annual targets updated to align with approved changes to SHIP success measures.
- Updated measurement language consistent with approved changes to SHIP success measures.
- Updated secondary driver language for consistency with updated success measures.
- Percent targets for secondary drivers reflect progress towards project goal value.

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Figure 1 – Driver Diagram

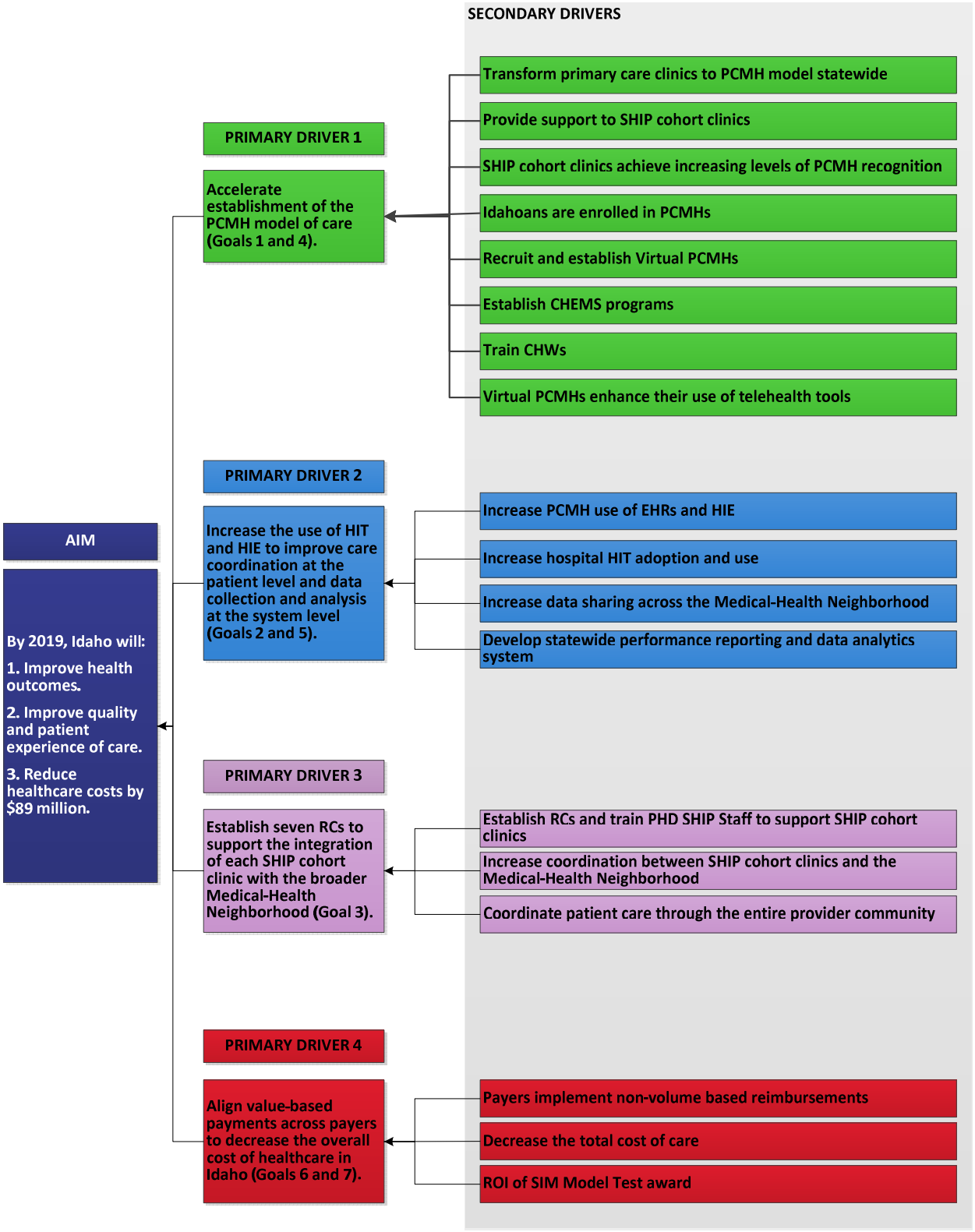

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Figure 2 – Metrics for Primary Driver 1

AIM

By 2019, Idaho will:
1. Improve health outcomes.
2. Improve quality and patient experience of care.
3. Reduce healthcare costs by $89 million.

PRIMARY DRIVER 1

Accelerate establishment of the PCMH model of care (Goals 1 and 4).

SECONDARY DRIVERS

SECONDARY DRIVERS	Measurement	AY1	AY2	AY3	AY4
Transform primary care clinics to PCMH model statewide	Primary care clinics that submit an interest survey to participate in a SHIP cohort	100 (37%)	200 (74%)	270 (100%)	270 (100%)
	Targeted primary care clinics selected for a SHIP cohort	0 (0%)	55 (33%)	110 (67%)	165 (100%)
	Primary care clinics selected for a SHIP cohort, of the total primary care clinics in Idaho	0 (0%)	55 (33%)	110 (67%)	165 (100%)
	Targeted providers participating in primary care clinics selected for a SHIP cohort	0 (0%)	550 (33%)	1,110 (67%)	1,650 (100%)
	Providers in primary care clinics selected for a SHIP cohort, of the total number of primary care providers in Idaho	0 (0%)	550 (33%)	1,110 (67%)	1,650 (100%)
	Primary care clinics selected for a SHIP cohort that achieve their transformation goals as specified in their Transformation Plan	0 (0%)	55 (33%)	110 (67%)	165 (100%)
Provide support to primary care clinics selected for a SHIP cohort	Primary care clinics selected for a SHIP cohort that have completed a PCMH readiness assessment and a Transformation Plan	0 (0%)	55 (33%)	110 (67%)	165 (100%)
	Primary care clinics selected for a SHIP cohort receiving an initial transformation incentive payment and achieving technical support benchmarks for retaining the payment	0 (0%)	55 (33%)	110 (67%)	165 (100%)
Primary care clinics selected for a SHIP cohort achieve increasing levels of PCMH recognition	Primary care clinics selected for a SHIP cohort that achieve national PCMH recognition/ accreditation	18 (11%)	30 (18%)	100 (61%)	165 (100%)
Idahoans are enrolled in primary care clinics selected for a SHIP cohort	Idahoans who enroll in a primary care clinic selected for a SHIP cohort (of total state population)	0 (0%)	275,000 (33%)	550,000 (67%)	825,000 (100%)
	Idahoans who enroll in a primary care clinic selected for a SHIP cohort (of target population)	0 (0%)	275,000 (33%)	550,000 (67%)	825,000 (100%)
Recruit and establish Virtual PCMHs	Virtual PCMHs established in rural communities following assessment of need	0 (0%)	15 (30%)	30 (60%)	50 (100%)
Establish CHEMS programs	Regional CHEMS programs established	1 (8%)	6 (46)%	11 (85%)	13 (100%)
	CHEMS program personnel trained for Virtual PCMH coordination	2 (6%)	16 (46%)	25 (71%)	35 (100%)
Train CHWs	New CHWs trained for Virtual PCMH coordination	0 (0%)	25 (20%)	75 (60%)	125 (100%)
	Continuing education conferences held for CHW and CHEMS Virtual PCMH staff	0 (0%)	0 (0%)	1 (50%)	2 (100%)
Virtual PCMHs enhance their use of telehealth tools	Designated Virtual PCMHs that routinely use telehealth tools to provide specialty and behavioral health services to rural patients	0 (0%)	12 (33%)	24 (67%)	36 (100%)

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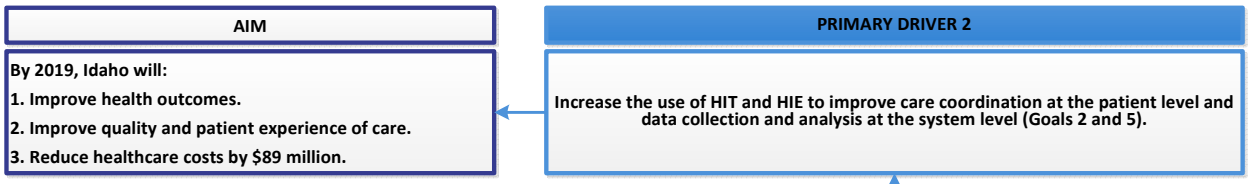
Figure 3 – Metrics for Primary Driver 2



SECONDARY DRIVERS

Measurement	AY1	AY2	AY3	AY4
Increase use of EHRs and HIE among primary care clinics selected for a SHIP cohort				
Primary care practices selected for a SHIP cohort with EHR systems that support HIE connectivity	0 (0%)	55 (33%)	110 (67%)	165 (100%)
Idahoans who enroll in a primary care practice selected for a SHIP cohort that have an EHR that is connected to HIE	0 (0%)	275,000 (33%)	550,000 (67%)	825,000 (100%)
Increase hospital HIT adoption and use				
Hospitals connected to the HIE and sharing data for care coordination	0 (0%)	15 (71%)	18 (86%)	21 (100%)
Increase data sharing across the Medical-Health Neighborhood				
Primary care practices selected for a SHIP cohort with an active connection to the HIE and sharing/receiving HIE transactions for care coordination	0 (0%)	55 (33%)	110 (67%)	165 (100%)
RCs provided a report of PCMH clinic CQM performance data	0 (0%)	0 (0%)	3 (43%)	7 (100%)
Develop statewide performance reporting and data analytics system				
Primary care practices selected for a SHIP cohort with access to the analytics system and dashboard reporting	0 (0%)	0 (0%)	60 (55%)	110 (100%)
Primary care practices selected for a SHIP cohort that are meeting the clinical quality reporting requirements for their cohort	0 (0%)	55 (33%)	110 (67%)	165 (100%)

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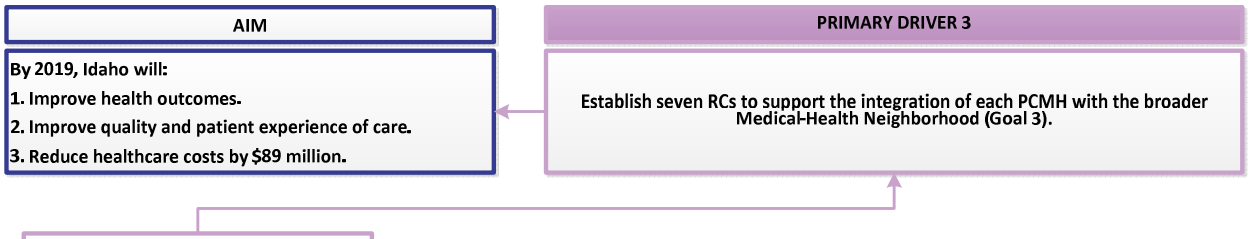
Figure 4 – Metrics for Primary Driver 3



SECONDARY DRIVERS

Measurement	AY1	AY2	AY3	AY4
Establish RCs and train PHD SHIP Staff to support primary care clinics selected for a SHIP cohort				
RCs established and providing regional quality improvement guidance and working with PHDs to integrate the Medical-Health Neighborhood	0 (0%)	7 (100%)	7 (100%)	7 (100%)
Primary care practices selected for a SHIP cohort that receive assistance through regional SHIP PHD team	0 (0%)	55 (33%)	110 (67%)	165 (100%)
Increase coordination between primary care practices selected for a SHIP cohort and the Medical-Health Neighborhood				
Primary care practices selected for a SHIP cohort who have established protocols for referrals and follow-up communications with service providers in their Medical-Health Neighborhood	0 (0%)	55 (33%)	110 (67%)	165 (100%)
Coordinate patient care through the entire provider community				
Patients enrolled in a primary care practice selected for a SHIP cohort whose health needs are coordinated across their local Medical-Health Neighborhood, as needed.	0 (0%)	275,000 (33%)	550,000 (67%)	825,000 (100%)

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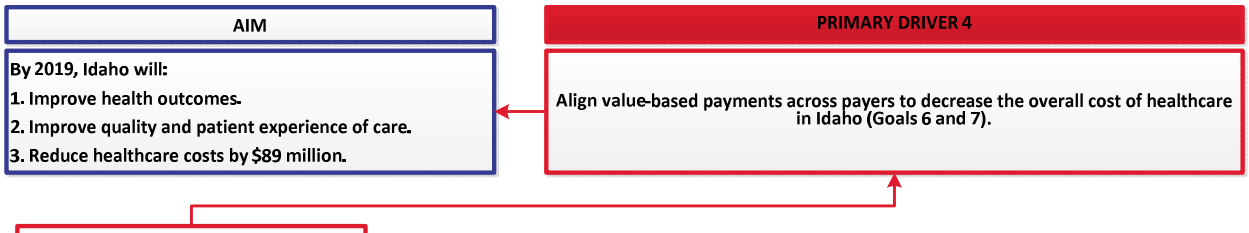
Figure 5 – Metrics for Primary Driver 4



SECONDARY DRIVERS

- Payers implement non-volume based reimbursements
- Decrease the total cost of care
- ROI of SIM Model Test award

Measurement	AY1	AY2	AY3	AY4
Payers representing at least 80% of the beneficiary population that adopt new reimbursement models.	0 (0%)	4 (100%)	4 (100%)	4 (100%)
Beneficiaries attributed to all providers for purposes of alternative reimbursement payments from SHIP participating payers	0 (0%)	275,000 (33%)	550,000 (67%)	825,000 (100%)
Payments made in non-FFS arrangements compared to the total payments made by SHIP participating payers	10%	20%	50%	80%
Total population-based PMPM index, defined as the total cost of care divided by the population risk score.	-	-	TBD	TBD
Annual financial analysis indicates cost savings and positive ROI. Target ROI for Model Test is 197%.	-	-	TBD	197%

A.4. Master Timeline

The master timeline is a comprehensive project plan that identifies the major tasks for SHIP in AY3 and their associated completion status and target dates. The master timeline also identifies where HIT activities support a component of the Model. Additional detail for these HIT activities can be found in Section B.4 of this Operational Plan (Goals 2 and 5).

For AY2 tasks, Idaho identified whether the task was completed. If the task was not completed, a new task end date has been provided and the reason for the incomplete task has been provided. Please refer to the master timeline on the next page.

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Figure 6 – AY3 Master Timeline

Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
1	**Patient Centered Medical Home (PCMH) Transformation**		**37%**	**Fri 5/1/15**	**Thu 1/31/19**		
1.1	**Develop and Recruitment and Enrollment Plan**		**78%**	**Mon 6/1/15**	**Thu 6/29/17**		
1.2	**Develop Interest Survey and Application for Enrollment in SHIP**		**51%**	**Wed 7/1/15**	**Wed 1/31/18**		**Incorporate collection of HIT capabilities in application process.**
1.3	**Develop SHIP PCMH Designation Criteria**		**85%**	**Mon 6/1/15**	**Tue 8/1/17**		**Incorporate HIT requirements in transformation process.**
1.4	**Hire a PCMH Contractor**	**Y**	**100%**	**Fri 5/1/15**	**Thu 12/3/15**		
1.4.1	Publish request for proposal (RFP)	Y	100%	Fri 5/1/15	Sun 5/31/15		
1.4.2	Select finalist	Y	100%	Mon 6/1/15	Mon 8/31/15		
1.4.3	Federal approval of contract	Y	100%	Tue 9/1/15	Thu 10/15/15		
1.4.4	Contract start date	Y	100%	Tue 10/20/15	Tue 10/20/15		
1.4.5	**Regular PCMH Project Management Reports**		**100%**	**Wed 11/4/15**	**Thu 12/3/15**		
1.4.5.1	Develop schedule, metrics, and format of regular reports	Y	100%	Wed 11/4/15	Wed 12/2/15		
1.4.5.2	Approve schedule, metrics, and format of regular reports	Y	100%	Wed 11/4/15	Wed 12/2/15		
1.4.5.3	Begin submitting regular reports to Idaho Department of Health and Welfare (IDHW)	Y	100%	Thu 12/3/15	Thu 12/3/15		
1.5	**Develop PCMH Transformation Plan and Tools**		**66%**	**Tue 12/1/15**	**Thu 1/31/19**		

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
1.5.1	**Transformation Portal**		**8%**	**Tue 12/1/15**	**Thu 1/31/19**		**Incorporate HIT capabilities to track and share status of transformation activities.**
1.5.1.1	Create transformation team portal	Y	100%	Tue 12/1/15	Fri 2/26/16		
1.5.1.2	Implement transformation team portal		33%	Mon 2/29/16	Thu 1/31/19		
1.6	**Develop PCMH Readiness Assessment**		**29%**	**Wed 11/4/15**	**Wed 11/29/17**		
1.6.1	Develop readiness assessment process and tools	Y	100%	Wed 11/4/15	Wed 12/2/15		
1.6.2	Approve readiness assessment process and tools	Y	100%	Thu 12/17/15	Thu 12/17/15		
1.6.3	Revise readiness assessment, as appropriate, for Cohort 2	N	50%	Tue 10/25/16	Wed 12/7/16	Readiness assessment revisions will be completed in December.	
1.6.4	Revise readiness assessment, as appropriate, for Cohort 3		0%	Thu 11/2/17	Wed 11/29/17		
1.7	**Select and Enroll Primary Care Practices**		**37%**	**Mon 8/3/15**	**Thu 5/31/18**		
1.7.1	**AY2 Cohort (Cohort 1)**		**100%**	**Mon 8/3/15**	**Fri 5/27/16**		
1.7.1.1	Primary care practices submit interest survey for Cohort 1	Y	100%	Mon 8/3/15	Mon 9/14/15		
1.7.1.2	Primary care practices submit application for Cohort 1	Y	100%	Fri 11/13/15	Mon 12/7/15		
1.7.1.3	Select first cohort of clinics for enrollment in the State Innovation Model (SIM) Model Test	Y	100%	Wed 12/2/15	Thu 12/10/15		
1.7.1.4	Conduct readiness assessment for Cohort 1 clinics	Y	100%	Fri 12/18/15	Thu 1/28/16		

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
1.7.1.5	Review results of readiness assessment of Cohort 1 clinics	Y	100%	Fri 12/18/15	Wed 1/20/16		
1.7.1.6	Clinics in Cohort 1 develop a transformation plan along with Public Health District (PHD) and Health Management Associates (HMA) staff	Y	100%	Mon 2/1/16	Fri 5/27/16		**Incorporate HIT requirements in transformation process.**
1.7.1.7	Upload Cohort 1 transformation plans to transformation portal	Y	100%	Fri 5/27/16	Fri 5/27/16		
1.7.2	**AY3 Cohort (Cohort 2)**		**17%**	**Mon 10/3/16**	**Mon 4/3/17**		
1.7.2.1	Primary care practices submit application for Cohort 2	Y	100%	Mon 10/3/16	Fri 10/28/16		
1.7.2.2	Identify second cohort of clinics for enrollment in the SIM Model Test	N	90%	Wed 11/30/16	Wed 12/14/16	Will be completed after submission of the Operational Plan.	
1.7.2.3	Schedule and conduct readiness assessment for Cohort 2	N	0%	Thu 12/15/16	Tue 1/31/17	Will be completed after submission of the Operational Plan.	
1.7.2.4	Review results of readiness assessment for Cohort 2 clinics	N	0%	Thu 12/15/16	Tue 1/31/17	Will be completed after submission of the Operational Plan.	
1.7.2.5	Sign contracts and memorandums of understanding (MOUs) with clinics	N	0%	Thu 12/15/16	Tue 1/31/17	Will be completed after submission of the Operational Plan.	
1.7.2.6	Clinics in Cohort 2 develop a transformation plan along with PHD and HMA staff		0%	Wed 2/1/17	Mon 4/3/17		**Incorporate HIT requirements in transformation process.**

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
1.7.2.7	Upload Cohort 2 transformation plans to transformation portal		0%	Mon 4/3/17	Mon 4/3/17		
1.7.3	**AY4 Cohort (Cohort 3)**		**0%**	**Fri 9/29/17**	**Thu 5/31/18**		
1.7.3.1	Primary care practices submit PCMH application for Cohort 3		0%	Fri 9/29/17	Fri 9/29/17		
1.7.3.2	Identify third cohort of clinics for enrollment in the SIM Model Test		0%	Tue 12/5/17	Wed 12/13/17		
1.7.3.3	Schedule and conduct readiness assessment for Cohort 3		0%	Thu 11/30/17	Wed 1/31/18		
1.7.3.4	Review results of readiness assessment for Cohort 3 clinics		0%	Thu 11/30/17	Wed 1/31/18		
1.7.3.5	Sign contracts and MOUs with clinics		0%	Thu 11/30/17	Wed 1/31/18		
1.7.3.6	Clinics in Cohort 3 develop a transformation plan along with PHD and HMA staff		0%	Thu 2/1/18	Wed 5/30/18		**Incorporate HIT requirements in transformation process.**
1.7.3.7	Upload Cohort 3 transformation plans to transformation portal		0%	Thu 5/31/18	Thu 5/31/18		
1.8	**Technical Assistance and Reimbursement for Primary Care Practices**		**36%**	**Tue 10/20/15**	**Thu 1/31/19**		
1.8.1	**Financial Reimbursement and Distribution**		**39%**	**Tue 10/20/15**	**Thu 1/31/19**		
1.8.1.1	**AY2 Distribution for Cohort 1**		**80%**	**Tue 10/20/15**	**Thu 1/31/19**		
1.8.1.1.1	Devise and implement financial reimbursement plan and system, including criteria for practices to receive the reimbursement and fraud/abuse protections	Y	100%	Tue 10/20/15	Mon 2/29/16		
1.8.1.1.2	Obtain any necessary approvals of the financial distribution process	Y	100%	Thu 11/19/15	Mon 3/21/16		

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
1.8.1.1.3	Devise and implement financial reimbursements to qualifying practices and implement fraud/abuse protections for AY2	N	75%	Thu 3/31/16	Thu 1/31/19	Distribution of reimbursements continues after submission of Operational Plan and continues through Model Test (for the national PCMH recognition payment).	
1.8.1.1.4	Develop financial accounting, monitoring and reporting system	Y	100%	Tue 12/1/15	Fri 1/29/16		
1.8.1.1.5	Monitor and track the use of funds and each clinic's reimbursement payment status	N	85%	Mon 2/1/16	Tue 1/31/17	Monitoring continues after submission of Operational Plan and continues through end of award year.	
1.8.1.1.6	IPM - recoupment reporting	N	66%	Thu 6/30/16	Tue 1/31/17	Reporting continues after submission of Operational Plan and continues through end of award year.	
1.8.1.2	**AY3 Distribution for Cohort 2**		**0%**	**Thu 2/2/17**	**Thu 1/31/19**		
1.8.1.2.1	Devise and implement financial reimbursements to qualifying practices and implement fraud/abuse protections for AY3		0%	Thu 2/2/17	Thu 1/31/19		
1.8.1.2.2	IPM - recoupment reporting		0%	Thu 2/2/17	Wed 1/31/18		

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
1.8.1.2.3	Monitor and track the use of funds and each clinic's reimbursement payment status		0%	Thu 2/2/17	Wed 1/31/18		
1.8.1.3	**AY4 Distribution for Cohort 3**		**0%**	**Wed 11/1/17**	**Thu 1/31/19**		
1.8.1.3.1	Evaluate and revise (as needed for AY4) financial distribution process and system, including criteria for practices to receive the reimbursement and fraud/abuse protections and obtain any necessary approvals		0%	Wed 11/1/17	Wed 1/31/18		
1.8.1.3.2	Distribute financial reimbursement to qualifying practices and implement fraud/abuse protections for AY4		0%	Thu 2/1/18	Thu 1/31/19		
1.8.1.3.3	IPM - recoupment reporting		0%	Thu 2/1/18	Thu 1/31/19		
1.8.1.3.4	Monitor and track the use of reimbursement funds and each clinic's reimbursement payment status		0%	Thu 2/1/18	Thu 1/31/19		
1.8.2	**Technical Support and Mentoring to PCMH Practices**		**36%**	**Tue 10/20/15**	**Thu 1/31/19**		
1.8.2.1	Develop methods and tools to provide support and mentoring to PCMH practices in topics related to transformation (PCMH training program)	Y	100%	Tue 10/20/15	Tue 1/19/16		
1.8.2.2	Implement support methods and tools (training program)		33%	Wed 1/20/16	Thu 1/31/19		
1.8.2.3	Modify support methods and tools (training program), as needed		33%	Wed 1/20/16	Thu 1/31/19		
1.8.3	**PHD SHIP Staff Training**		**33%**	**Mon 2/1/16**	**Thu 1/31/19**		
1.8.3.1	Provide coordinated training and technical assistance for PHD SHIP staff, including learning collaboratives		33%	Mon 2/1/16	Thu 1/31/19		

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
1.8.4	**Stakeholder Communications regarding SHIP Clinics**		**33%**	**Mon 2/1/16**	**Thu 1/31/19**		
1.8.4.1	Communicate with stakeholders regarding SHIP clinics		33%	Mon 2/1/16	Thu 1/31/19		
2	**Develop Health Information Technology (HIT) Infrastructure**		**18%**	**Mon 2/1/16**	**Thu 1/31/19**		**All activities under Goal 2 are HIT-related.**
2.1	**Project Management & Contract Activities**		**44%**	**Mon 2/1/16**	**Fri 6/30/17**		**Establish SHIP HIT vendors and project management.**
2.1.1	Project Work Plan	Y	100%	Mon 8/1/16	Mon 8/1/16		
2.1.2	Complete IHDE/SHIP Contracting (current year)	Y	100%	Mon 2/1/16	Thu 4/28/16		
2.1.3	Conduct contracting preparation for subsequent year	Y	100%	Mon 10/3/16	Fri 12/16/16		
2.1.4	**CQM Data Quality Process**		**0%**	**Thu 12/1/16**	**Fri 6/30/17**		**Establish process and mechanism for addressing individual clinic data quality related to CQM production.**
2.1.4.1	Preliminary discussion regarding structure and membership of CQM Data Quality Process	N	0%	Thu 12/1/16	Wed 12/14/16	Will be completed after submission of the Operational Plan.	
2.1.4.2	Develop CQM Data Quality Process charge (guiding document)	N	0%	Wed 12/14/16	Tue 1/31/17	Will be completed after submission of the Operational Plan.	
2.1.4.3	Identify members/roles for the CQM Data Quality Process		0%	Tue 1/31/17	Fri 6/30/17		
2.1.4.4	Establish meeting schedule		0%	Fri 6/30/17	Fri 6/30/17		

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
2.1.5	**SHIP HIT Data Governance**		**9%**	**Thu 12/1/16**	**Fri 6/30/17**		**Establish workgroup to help govern data standards.**
2.1.5.1	ONC TA – Idaho stakeholder engagement and restructure of existing workgroups	N	25%	Fri 10/7/16	Tue 12/20/16	Onsite TA has been scheduled. Will be completed after Operational Plan submission.	
2.1.5.2	Develop structure and membership for SHIP HIT Governance.	N	0%	Tue 12/21/16	Fri 1/27/17	Will be completed after Operational Plan submission.	
2.1.5.3	Identify member for the SHIP HIT Governance group.		**0%**	Wed 1/2/17	Fri 3/31/17		
2.1.5.4	Draft HIT Governance Charter		**0%**	Fri 3/31/17	Fri 6/2/17		
2.1.5.5.	Establish meeting schedule		**0%**	Fri 6/2/17	Fri 6/30/17		
2.2	**Readiness Assessment (RA) Prep**		**19%**	**Thu 4/28/16**	**Fri 2/2/18**		**Review SHIP applications to gather information related to HIT readiness.**
2.2.1	**SHIP Applications Review - Readiness Assessment Prep - Cohort 1**		**100%**	**Thu 4/28/16**	**Thu 5/26/16**		
2.2.1.1	Receive SHIP listing - Cohort 1	Y	100%	Thu 4/28/16	Thu 4/28/16		
2.2.1.2	Receive SHIP applications - Cohort 1	Y	100%	Mon 5/2/16	Fri 5/6/16		
2.2.1.3	Verify accuracy of SHIP applications to main list - Cohort 1	Y	100%	Mon 5/9/16	Fri 5/13/16		
2.2.1.4	Organize SHIP applications into IHDE folders - Cohort 1	Y	100%	Mon 5/16/16	Wed 5/18/16		
2.2.1.5	Develop draft RA and organize into Cohort 1 folders	Y	100%	Wed 5/18/16	Tue 5/24/16		

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
2.2.1.6	Distribute approved RAs - Cohort 1	N	100%	Wed 5/25/16	Thu 5/26/16	Anticipated to be completed by end of AY2 due to contractor delays.	
2.2.2	**SHIP Applications Review - Readiness Assessment Prep - Cohort 2**		**0%**	**Thu 12/15/16**	**Fri 4/7/17**		
2.2.2.1	Receive SHIP listing - Cohort 2	N	0%	Thu 12/15/16	Fri 12/16/16	Will be completed after submission of the Operational Plan.	
2.2.2.2	Receive SHIP applications - Cohort 2	N	0%	Fri 12/23/16	Fri 12/23/16	Will be completed after submission of the Operational Plan.	
2.2.2.3	Verify accuracy of SHIP applications to main list - Cohort 2	N	0%	Mon 12/26/16	Tue 12/27/16	Will be completed after submission of the Operational Plan.	Determine the level of HIT readiness for each clinic.
2.2.2.4	Organize SHIP applications into IHDE folders - Cohort 2	N	0%	Wed 12/28/16	Fri 12/30/16	Will be completed after submission of the Operational Plan.	
2.2.2.5	Develop draft RA and organize into Cohort 2 folders	N	0%	Mon 1/2/17	Fri 3/31/17	Will be completed after submission of the Operational Plan.	Develop document capturing findings from readiness assessment.
2.2.2.6	Distribute approved RAs - Cohort 2	N	0%	Mon 4/3/17	Fri 4/7/17	Will be completed after submission of the Operational Plan.	Provide information to clinics to address weaknesses.
2.2.3	**SHIP Applications Review - Readiness Assessment Prep - Cohort 3**		**0%**	**Sun 10/1/17**	**Fri 2/2/18**		

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
2.2.3.1	Develop schedule for list/applications - Cohort 3		0%	Sun 10/1/17	Sun 10/15/17		
2.2.3.2	Complete list/application tasks for Cohort 3		0%	Fri 12/1/17	Fri 2/2/18		
2.3	**Training for Readiness Assessment**		**29%**	**Sun 5/1/16**	**Mon 12/31/18**		**Provide training to clinics on what to expect during the HIT readiness assessment.**
2.3.1	Develop Training Plan	Y	100%	Sun 5/1/16	Sun 4/30/17		
2.3.2	Training - Cohort 1 - Phase 1	Y	100%	Wed 6/1/16	Mon 10/31/16		
2.3.3	Training - Cohort 1 - Phase 2	N	66%	Tue 11/1/16	Sun 4/30/17	Anticipated to be completed once clinic connections are completed in AY3.	
2.3.4	Training - Cohort 2		0%	Wed 3/1/17	Tue 10/31/17		
2.3.5	Training - Cohort 3		0%	Wed 3/1/17	Wed 10/31/18		
2.3.6	Training - Clinics pending EMR conversions		0%	Fri 3/31/17	Mon 12/31/18		
2.4	**Complete Readiness Assessments**		**5%**	**Mon 8/15/16**	**Thu 1/31/19**		**Conduct readiness assessments to determine the clinics' capacity to connect to IHDE and exchange data.**
2.4.1	**Readiness Assessments - Cohort 1**		**34%**	**Mon 8/15/16**	**Sun 4/30/17**		
2.4.1.1	Readiness Assessments - Cohort 1 - Phase 1	Y	100%	Mon 8/15/16	Mon 10/31/16		
2.4.1.2	Readiness Assessments - Cohort 1 - Phase 2	N	50%	Thu 12/1/16	Sun 4/30/17	Anticipated to be completed at the start of AY3.	

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
2.4.2	Readiness Assessments - Cohort 2		0%	Wed 2/1/17	Tue 10/31/17		
2.4.3	Readiness Assessments - Cohort 3		0%	Thu 2/1/18	Wed 10/31/18		
2.4.4	Readiness Assessments - clinics pending EMR conversions (Cohorts 1, 2, 3)		0%	Sat 4/1/17	Thu 1/31/19		
2.5	**Build Connections**		**5%**	**Mon 8/15/16**	**Thu 1/31/19**		**Build connections to the HIE to facilitate data exchange and reporting.**
2.5.1	**Build Connections - Cohort 1**		**34%**	**Mon 8/15/16**	**Sun 4/30/17**		
2.5.1.1	Connection builds Cohort 1 - Phase 1	Y	100%	Mon 8/15/16	Mon 10/31/16		
2.5.1.2	Connection builds Cohort 1 - Phase 2	N	0%	Thu 12/1/16	Sun 4/30/17	Builds will continue into AY3.	
2.5.2	Build connections - Cohort 2		0%	Wed 2/1/17	Tue 10/31/17		
2.5.3	Build connections - Cohort 3		0%	Thu 2/1/18	Wed 10/31/18		
2.5.4	Connection builds - clinics pending EMR conversions		0%	Sat 4/1/17	Thu 1/31/19		
2.6	**Administer Payment of IHDE Licensing Fees**		**5%**	**Mon 8/15/16**	**Thu 1/31/19**		**Pay for licensing fees required to connect to the HIE.**
2.6.1	**Administer Payments of IHDE Licensing Fees - Cohort 1**	N	**34%**	**Mon 8/15/16**	**Sun 4/30/17**	Will continue into AY3.	
2.6.2	**Administer payments of IHDE licensing fees - Cohort 2**		**0%**	**Wed 2/1/17**	**Tue 10/31/17**		
2.6.3	**Administer payments of IHDE licensing fees - Cohort 3**		**0%**	**Thu 2/1/18**	**Wed 10/31/18**		
2.7	**Administer Payment of EMR Vendor Fees**		**5%**	**Mon 8/15/16**	**Thu 1/31/19**		**Pay for EMR vendor fees required to connect to the HIE.**
2.7.1	**Administer Payments of EMR Vendor Fees - Cohort 1**		**34%**	**Mon 8/15/16**	**Sun 4/30/17**		

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
2.7.1.1	Phase 1 Clinics	N	50%	Mon 8/15/16	Mon 10/31/16	IHDE (and subcontractors) have struggled with resources to complete builds. Cost overruns have further contributed to delays.	
2.7.1.2	Phase 2 Clinics	N	0%	Thu 12/1/16	Sun 4/30/17	Builds will continue into AY3.	
2.7.2	Administer payments of EMR vendor fees - Cohort 2		0%	Wed 2/1/17	Tue 10/31/17		
2.7.3	Administer payments of EMR vendor fees - Cohort 3		0%	Thu 2/1/18	Wed 10/31/18		
2.8	**Payer Feasibility Study**		**25%**	**Thu 10/6/16**	**Mon 12/31/16**		**Evaluate the feasibility of expanding IHDE to include payer data.**
2.8.1	IHDE submits payer feasibility study	N	0%	Thu 10/6/16	Thu 12/29/16	Will be completed after submission of the Operational Plan.	
2.8.2	IDHW reviews payer feasibility study	N	0%	Fri 12/30/16	Fri 1/13/17	Will be completed after submission of the Operational Plan.	
2.8.3	IDHW responds to payer feasibility study	N	0%	Mon 1/16/17	Mon 1/16/17	Will be completed after submission of the Operational Plan.	

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
2.9	**Regional Database Base Feasibility Study**		**25%**	**Fri 11/4/16**	**Mon 1/30/16**		**Evaluate the feasibility of expanding IHDE to include regional database data.**
2.9.1	IHDE submits regional Database feasibility study	N	0%	Fri 11/4/16	Fri 1/6/16	Will be completed after submission of the Operational Plan.	
2.9.2	IDHW reviews regional Database feasibility study	N	0%	Mon 1/9/16	Thu 1/19/16	Will be completed after submission of the Operational Plan.	
2.9.3	IDHW responds to regional Database feasibility study	N	0%	Mon 1/23/16	Mon 1/30/16	Will be completed after submission of the Operational Plan.	
2.10	**Quality Assurance Plan**		**100%**	**Fri 9/9/16**	**Thur 12/1/16**		**Develop QA plan to ensure data reliability and accuracy.**
2.10.1	Submit quality assurance plan	Y	100%	Fri 9/9/16	Fri 9/9/16		
2.10.2	Review quality assurance plan	Y	100%	Mon 9/12/16	Fri 9/23/16		
2.10.3	Respond to quality assurance plan	N	75%	Mon 9/26/16	Thur 12/1/16	Will be completed after submission of the Operational Plan.	
2.11	**Coordinate Activities with Analytics Vendor**		**1%**	**Mon 6/20/16**	**Sun 7/1/18**		**Secure proper protections and security standards for data exchange.**

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
2.11.1	Develop privacy and security - data sharing agreement	Y	100%	Mon 6/20/16	Mon 6/20/16		
2.11.2	Review privacy and security agreements - Cohort 2		0%	Mon 5/15/17	Sat 7/1/17		
2.11.3	Review privacy and security agreements - Cohort 3		0%	Tue 5/15/18	Sun 7/1/18		
2.12	**Requirements Phase Clinical Quality Measure (CQM) Specs**		**34%**	**Sun 5/1/16**	**Fri 6/1/18**		**Develop requirements for CQMs that will be reported by all clinics selected for a SHIP cohort.**
2.12.1	Develop CQM Specs AY2	Y	100%	Sun 5/1/16	Wed 8/31/16		
2.12.2	Develop CQM Specs AY3		0%	Wed 2/1/17	Thu 6/1/17		
2.12.3	Develop CQM Specs AY4		0%	Thu 2/1/18	Fri 6/1/18		
2.13	**Support CQM Proof of Concept**		**100%**	**Fri 7/1/16**	**Tue 1/31/17**		**Develop requirements and acceptance criteria for vendor CQM product**
2.13.1	Confirm requirements	Y	100%	Fri 7/1/16	Thu 9/1/16		
2.13.2	Engage subcontractors	Y	100%	Fri 7/1/16	Fri 9/30/16		
2.13.3	Share sample data	Y	100%	Mon 8/1/16	Tue 1/31/17		
2.14	**Requirements Phase**		**32%**	**Tue 9/6/16**	**Mon 7/30/18**		
2.14.1	Define data extraction process - AY2	Y	100%	Tue 9/6/16	Mon 10/31/16		
2.14.2	Define data extraction process - AY3		0%	Thu 6/1/17	Sun 7/30/17		
2.14.3	Define data extraction process - AY4		0%	Fri 6/1/18	Mon 7/30/18		
2.15	**Develop Solution for Behavioral Health (BH) data**		**62%**	**Tue 9/6/16**	**Tue 1/31/17**		
2.15.1	Review Policies and identify IHDE recommendations	Y	100%	Tue 9/6/16	Fri 9/16/16		

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
2.15.2	Division of BH review IHDE's recommendations	Y	100%	Fri 9/23/16	Fri 9/23/16		
2.15.3	Identify clinics impacts	Y	100%	Mon 9/26/16	Tue 1/31/17		
2.15.4	IDHW, IHDE and Division of BH develop state policy related to BH data	N	50%	Tue 11/1/16	Fri 12/30/16	Will be completed after submission of the Operational Plan.	
2.15.5	Obtain IHDE approval of state policy	N	0%	Tue 1/3/17	Tue 1/10/17	Will be completed after submission of the Operational Plan.	
2.15.6	Develop protocol for BH filtering of data	N	0%	Tue 1/10/17	Wed 1/25/17	Will be completed after submission of the Operational Plan.	
3	**Regional Collaboratives**		**40%**	**Fri 5/1/15**	**Fri 3/1/19**		
3.1	**Establish Regional Health Collaboratives**		**67%**	**Fri 5/1/15**	**Wed 5/31/17**		
3.1.1	Negotiate initial contracts with Public Health Districts (PHDs) (2015-2016)	Y	100%	Fri 5/1/15	Tue 6/30/15		
3.1.2	Execute contract with 7 PHDs	Y	100%	Wed 7/1/15	Fri 7/31/15		
3.1.3	Hire SHIP PHD staff (SHIP Manager, Quality Improvement (QI) Specialist)	Y	100%	Mon 8/3/15	Sat 10/31/15		
3.1.4	Identify RC Executive Leadership Team (RCE)	Y	100%	Mon 11/2/15	Mon 11/30/15		
3.1.5	Convene RCE	Y	100%	Mon 11/2/15	Mon 11/30/15		
3.1.6	Establish RC general membership	Y	100%	Tue 12/1/15	Mon 4/4/16		
3.1.7	Develop strategic plan for each RC	Y	100%	Thu 9/1/16	Thu 9/1/16		
3.1.8	Develop and implement grant program to support RCs		0%	Thu 12/1/16	Tue 2/28/17		
3.1.9	Award grants to support RCs		0%	Wed 3/1/17	Wed 5/31/17		

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
3.2	**Renew Contracts with PHDs**		**37%**	**Fri 7/15/16**	**Wed 1/31/18**		
3.2.1	Discuss anticipated scope (including roles and responsibilities) language in PHD contract	Y	100%	Fri 7/15/16	Mon 10/31/16		
3.2.2	Negotiate contracts with PHDs (February 2017)		0%	Tue 11/1/16	Tue 1/31/17		
3.2.3	Negotiate contracts with PHDs (February 2018)		0%	Wed 11/1/17	Wed 1/31/18		
3.3	**Integrate Medical-Health Neighborhoods**		**27%**	**Thu 9/1/16**	**Wed 11/14/18**		
3.3.1	**Define Medical-Health Neighborhood**		**75%**	**Thu 9/1/16**	**Wed 3/29/17**		
3.3.1.1	Identify participants in the Medical-Health Neighborhood in each region	Y	100%	Thu 9/1/16	Tue 11/22/16		
3.3.1.2	Attend NCQA Congress in Chicago (Medical-Health Neighborhood topics)	Y	100%	Thu 10/6/16	Sat 10/8/16		
3.3.1.3	Assess the list of Medical-Health Neighborhood participants to identify gaps		0%	Wed 3/1/17	Tue 3/28/17		
3.3.1.4	Distribute the list of Medical-Health Neighborhood participants to IDHW and SHIP Clinics		0%	Wed 3/29/17	Wed 3/29/17		
3.3.2	Develop communication plan and materials for integration efforts		0%	Wed 9/7/16	Fri 3/31/17		
3.3.3	**Report to the IHC the status of integrating Medical-Health Neighborhoods**		**33%**	**Wed 11/9/16**	**Wed 11/14/18**		
3.3.3.1	Initial Report	Y	100%	Wed 11/9/16	Wed 11/9/16		
3.3.3.2	2nd Report to IHC		0%	Wed 11/8/17	Wed 11/8/17		
3.3.3.3	Final Report to IHC		0%	Wed 11/14/18	Wed 11/14/18		
3.4	**RCs Provide Regional Quality Improvement Guidance**		**42%**	**Wed 7/22/15**	**Fri 3/1/19**		

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
3.4.1	Define regional quality improvement guidance to be provided by RCs	Y	100%	Wed 7/22/15	Mon 8/31/15		
3.4.2	Develop a strategic plan for each RC	Y	100%	Thu 9/1/16	Tue 11/1/16		
3.4.3	IDHW/IHC review strategic plans	Y	100%	Wed 11/2/16	Thu 12/1/16		
3.4.4	Present RC strategic plans to IHC	Y	100%	Wed 11/9/16	Wed 11/9/16		
3.4.5	Approve RC strategic plans	N	0%	Wed 12/14/16	Wed 12/14/16	Will be completed after submission of the Operational Plan.	
3.4.6	Begin implementing strategic plans for each RC		0%	Wed 2/1/17	Wed 2/1/17		
3.4.7	**Submit Annual Status Report**		**0%**	**Wed 3/1/17**	**Fri 3/1/19**		
3.4.7.1	Annual report for 2016		0%	Wed 3/1/17	Wed 3/1/17		
3.4.7.2	Annual report for 2017		0%	Thu 3/1/18	Thu 3/1/18		
3.4.7.3	Annual report for 2018		0%	Fri 3/1/19	Fri 3/1/19		
3.4.8	**Communication to SHIP Clinics Regarding Availability of Transformation Support**		**0%**	**Tue 11/1/16**	**Tue 1/30/18**		
3.4.8.1	Develop communication	N	0%	Tue 11/1/16	Thu 12/1/16	Will be completed after submission of the Operational Plan.	
3.4.8.2	Review/revise communication	N	0%	Tue 11/1/16	Thu 12/1/16	Will be completed after submission of the Operational Plan.	
3.4.8.3	Finalize communication		0%	Fri 12/2/16	Mon 1/2/17		
3.4.8.4	Initial communication with SHIP Clinics - 2016		0%	Tue 1/3/17	Tue 1/31/17		
3.4.8.5	Annual communication with SHIP Clinics - 2017		0%	Mon 1/2/17	Mon 1/30/17		

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
3.4.8.6	Annual communication with SHIP Clinics - 2018		0%	Tue 1/2/18	Tue 1/30/18		
3.5	**Evaluation Plan to Ensure RCs Provide Regional QI Guidance**		**0%**	**Thu 9/1/16**	**Wed 2/1/17**		
3.5.1	Develop plan	N	0%	Thu 9/1/16	Tue 1/3/17	Will be completed after submission of the Operational Plan.	
3.5.2	Review/revise plan	N	0%	Thu 9/1/16	Tue 1/3/17	Will be completed after submission of the Operational Plan.	
3.5.3	Finalize plan	N	0%	Wed 1/4/17	Wed 2/1/17	Will be completed after submission of the Operational Plan.	
3.5.4	Implement plan		0%	Wed 2/1/17	Wed 2/1/17		
3.6	**RC Granting Program**		**0%**	**Mon 11/7/16**	**Fri 1/31/19**		
3.6.1	**Award Year 3 RC Program**		22%	Mon 11/7/16	Thu 1/31/19		
3.6.1.1	Planning	Y	100%	Mon 11/7/16	Fri 11/11/16		
3.6.1.2	Kick-off webinar	Y	100%	Mon 11/14/16	Mon 11/14/16		
3.6.1.3	Application Period	N	50%	Tue 11/15/16	Fri 12/9/16	Will be completed after submission of the Operational Plan.	
3.6.1.4	Scoring	N	0%	Mon 12/12/16	Fri 12/16/16	Will be completed after submission of the Operational Plan.	

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
3.6.1.5	Funding Request to CMMI and OAGM	N	0%	Wed 12/21/16	Tue 1/31/17	Will be completed after submission of the Operational Plan.	
3.6.1.6	Award to RC Scoring		0%	Wed 2/1/17	Tue 1/30/18		
3.6.1.7	Monitoring		0%	Wed 2/1/17	Tue 1/30/18		
3.6.1.8	Closeout		0%	Wed 1/31/17	Wed 1/31/18		
3.6.2	**Award Year 4 RC Program**		0%	Tue 11/1/17	Thu 1/31/19		
3.6.2.1	Planning		0%	Mon 11/6/17	Fri 11/10/17		
3.6.2.2	Kick-off webinar		0%	Mon 11/13/17	Mon 11/13/17		
3.6.2.3	Application Period		0%	Tue 11/14/17	Fri 12/8/17		
3.6.2.4	Scoring		0%	Mon 12/11/17	Fri 12/15/17		
3.6.2.5	Funding Request to CMMI and OAGM		0%	Wed 12/20/16	Wed 1/31/18		
3.6.2.6	Award to RC Scoring		0%	Thu 2/1/18	Wed 1/30/19		
3.6.2.7	Monitoring		0%	Thu 2/1/18	Wed 1/30/19		
3.6.2.8	Closeout		0%	Thu 1/31/19	Thu 1/31/19		
4	**Virtual PCMHs**		**12%**	**Tue 12/1/15**	**Thu 1/31/19**		
4.1	**SHIP Virtual PCMH Program Design and Evaluation**		**7%**	**Wed 7/20/16**	**Thu 1/31/19**		
4.1.1	**Designation of Virtual PCMHs**		**7%**	**Wed 7/20/16**	**Thu 1/31/19**		
4.1.1.1	**Develop Virtual PCMH Requirements, Standards, and Designation Process**		**5%**	**Wed 7/20/16**	**Wed 1/4/17**		
4.1.1.1.1	**Develop Requirements and Standards**		**0%**	**Thu 12/1/16**	**Wed 1/4/17**		
4.1.1.1.1.1	**Community Health Workers (CHWs)**		**0%**	**Thu 12/1/16**	**Wed 1/4/17**		

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
4.1.1.1.1.1.1	Meet with CHW planning group to discuss requirements for CHW component of Virtual PCMHs	N	0%	Thu 12/1/16	Wed 12/7/16	Will be completed after submission of the Operational Plan.	
4.1.1.1.1.1.2	Document requirements for CHW component of Virtual PCMHs and send for review	N	0%	Thu 12/8/16	Wed 12/14/16	Will be completed after submission of the Operational Plan.	
4.1.1.1.1.1.3	CHW planning group reviews requirements documentation for CHW component of Virtual PCMHs	N	0%	Thu 12/15/16	Wed 12/21/16	Will be completed after submission of the Operational Plan.	
4.1.1.1.1.1.4	Finalize requirements documentation for CHW component of Virtual PCMHs	N	0%	Thu 12/22/16	Wed 12/28/16	Will be completed after submission of the Operational Plan.	
4.1.1.1.1.1.5	Approve requirements for CHW component of Virtual PCMHs	N	0%	Thu 12/29/16	Wed 1/4/17	Will be completed after submission of the Operational Plan.	
4.1.1.1.1.2	**Community Health Emergency Medical Services (CHEMS)**		**0%**	**Thu 12/1/16**	**Wed 1/4/17**		
4.1.1.1.1.2.1	Meet with CHEMS WG to discuss requirements for CHEMS component of Virtual PCMHs	N	0%	Thu 12/1/16	Wed 12/7/16	Will be completed after submission of the Operational Plan.	
4.1.1.1.1.2.2	Document requirements for CHEMS component of Virtual PCMHs and send for review	N	0%	Thu 12/8/16	Wed 12/14/16	Will be completed after submission of the Operational Plan.	**Incorporate HIT requirements related to reporting data for CHEMS metrics.**

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
4.1.1.1.1.2.3	CHEMS WG reviews requirements documentation for CHEMS component of Virtual PCMHs	N	0%	Thu 12/15/16	Wed 12/21/16	Will be completed after submission of the Operational Plan.	
4.1.1.1.1.2.4	Finalize requirements documentation for CHEMS component of Virtual PCMHs	N	0%	Thu 12/22/16	Wed 12/28/16	Will be completed after submission of the Operational Plan.	
4.1.1.1.1.2.5	Approve requirements for CHEMS component of Virtual PCMHs	N	0%	Thu 12/29/16	Wed 1/4/17	Will be completed after submission of the Operational Plan.	
4.1.1.1.1.3	**Telehealth**		**0%**	**Thu 12/1/16**	**Wed 1/4/17**		
4.1.1.1.1.3.1	Meet to discuss requirements for telehealth component of Virtual PCMHs	N	0%	Thu 12/1/16	Wed 12/7/16	Will be completed after submission of the Operational Plan.	**Determine requirements associated with telehealth equipment.**
4.1.1.1.1.3.2	Document requirements for telehealth component of Virtual PCMHs and send for review	N	0%	Thu 12/8/16	Wed 12/14/16	Will be completed after submission of the Operational Plan.	
4.1.1.1.1.3.3	Telehealth Subcommittee reviews requirements documentation for telehealth component of Virtual PCMHs	N	0%	Thu 12/15/16	Wed 12/21/16	Will be completed after submission of the Operational Plan.	
4.1.1.1.1.3.4	Finalize requirements documentation for telehealth component of Virtual PCMHs	N	0%	Thu 12/22/16	Wed 12/28/16	Will be completed after submission of the Operational Plan.	**Establish HIT requirements for telehealth.**

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
4.1.1.1.1.3.5	Approve requirements for telehealth component of Virtual PCMHs	N	0%	Thu 12/29/16	Wed 1/4/17	Will be completed after submission of the Operational Plan.	**Establish HIT requirements for telehealth.**
4.1.1.1.2	**Develop Designation Process**		**0%**	**Thu 12/1/16**	**Wed 12/28/16**		
4.1.1.1.2.1	**CHW**		**0%**	**Thu 12/1/16**	**Wed 12/28/16**		
4.1.1.1.2.1.1	Design designation process for CHW component of Virtual PCMHs	N	0%	Thu 12/1/16	Wed 12/14/16	Will be completed after submission of the Operational Plan.	
4.1.1.1.2.1.2	Review designation process for CHW component of Virtual PCMHs	N	0%	Thu 12/15/16	Wed 12/21/16	Will be completed after submission of the Operational Plan.	
4.1.1.1.2.1.3	Approve designation process for CHW component of Virtual PCMHs	N	0%	Thu 12/22/16	Wed 12/28/16	Will be completed after submission of the Operational Plan.	
4.1.1.1.2.2	**CHEMS**		**0%**	**Thu 12/1/16**	**Wed 12/28/16**		
4.1.1.1.2.2.1	Design designation process for CHEMS component of Virtual PCMHs	N	0%	Thu 12/1/16	Wed 12/14/16	Will be completed after submission of the Operational Plan.	
4.1.1.1.2.2.2	Review designation process for CHEMS component of Virtual PCMHs	N	0%	Thu 12/15/16	Wed 12/21/16	Will be completed after submission of the Operational Plan.	
4.1.1.1.2.2.3	Approve designation process for CHEMS component of Virtual PCMHs	N	0%	Thu 12/22/16	Wed 12/28/16	Will be completed after submission of the Operational Plan.	
4.1.1.1.2.3	**Telehealth**		**0%**	**Thu 12/1/16**	**Wed 12/28/16**		

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
4.1.1.1.2.3.1	Design designation process for telehealth component of Virtual PCMHs	N	0%	Thu 12/1/16	Wed 12/14/16	Will be completed after submission of the Operational Plan.	**Establish HIT requirements for telehealth.**
4.1.1.1.2.3.2	Review designation process for telehealth component of Virtual PCMHs	N	0%	Thu 12/15/16	Wed 12/21/16	Will be completed after submission of the Operational Plan.	**Establish HIT requirements for telehealth.**
4.1.1.1.2.3.3	Approve designation process for telehealth component of Virtual PCMHs	N	0%	Thu 12/22/16	Wed 12/28/16	Will be completed after submission of the Operational Plan.	**Establish HIT requirements for telehealth.**
4.1.1.1.3	**Establish Reimbursements for Virtual PCMHs**		**100%**	**Wed 7/20/16**	**Thu 7/28/16**		
4.1.1.1.3.1	Devise and implement financial reimbursement distribution process, including criteria for practices to receive the reimbursement and fraud/abuse protections	Y	100%	Wed 7/20/16	Thu 7/28/16		**Establish process for distributing funds electronically to clinics designated as Virtual PCMH.**
4.1.1.2	**Develop Virtual PCMH Recruitment Plan**		**100%**	**Tue 11/1/16**	**Mon 11/14/16**		
4.1.1.2.1	**Draft Virtual PCMH Recruitment Plan**		**100%**	**Tue 11/1/16**	**Mon 11/7/16**		
4.1.1.2.1.1	CHW component of recruitment plan	Y	100%	Tue 11/1/16	Mon 11/7/16		
4.1.1.2.1.2	CHEMS component of recruitment plan	Y	100%	Tue 11/1/16	Mon 11/7/16		
4.1.1.2.1.3	Telehealth component of recruitment plan	Y	100%	Tue 11/1/16	Mon 11/7/16		
4.1.1.2.2	**Draft Outreach Materials**		**100%**	**Tue 11/8/16**	**Mon 11/14/16**		
4.1.1.2.2.1	CHW outreach materials	Y	100%	Tue 11/8/16	Mon 11/14/16		
4.1.1.2.2.2	CHEMS outreach materials	Y	100%	Tue 11/8/16	Mon 11/14/16		

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
4.1.1.2.2.3	Telehealth outreach materials	Y	100%	Tue 11/8/16	Mon 11/14/16		
4.1.1.3	**Implement Virtual PCMH Recruitment Plan**		**7%**	**Tue 11/8/16**	**Wed 5/31/17**		
4.1.1.3.1	Training for PHD SHIP Staff on Virtual PCMH Recruitment Plan	Y	100%	Tue 11/8/16	Mon 11/21/16		
4.1.1.3.2	Recruit Virtual PCMHs for Cohort 1 clinics		0%	Tue 11/22/16	Wed 5/31/17		
4.1.1.4	**Designate SHIP Clinics as Virtual PCMHs**		**0%**	**Thu 12/29/16**	**Thu 1/31/19**		
4.1.1.4.1	**Cohort 1 Clinics**		**0%**	**Thu 12/29/16**	**Wed 5/31/17**		
4.1.1.4.1.1	Application submission and review		0%	Thu 12/29/16	Wed 5/31/17		
4.1.1.4.1.2	Complete distribution of financial Reimbursements		0%	Thu 2/23/17	Wed 5/31/17		
4.1.1.4.2	**Cohort 2 Clinics**		**0%**	**Wed 11/1/17**	**Tue 1/30/18**		
4.1.1.4.2.1	Application submission and review		0%	Wed 11/1/17	Thu 11/30/17		
4.1.1.4.2.2	Complete distribution of financial reimbursements		0%	Fri 12/1/17	Tue 1/30/18		
4.1.1.4.3	**Cohort 3 Clinics**		**0%**	**Thu 11/1/18**	**Thu 1/31/19**		
4.1.1.4.3.1	Application submission and review		0%	Thu 11/1/18	Fri 11/30/18		
4.1.1.4.3.2	Complete distribution of financial reimbursments		0%	Mon 12/3/18	Thu 1/31/19		
4.2	**CHEMS**		**14%**	**Tue 12/1/15**	**Thu 1/31/19**		
4.2.1	**Establish In-State Training Programs for CHEMS**		**14%**	**Tue 12/1/15**	**Thu 1/31/19**		
4.2.1.1	**Initial CHEMS Training Program**		**37%**	**Tue 12/1/15**	**Mon 5/1/17**		
4.2.1.1.1	Establish CHEMS Workgroup and identify CHEMS sub-committee leads	Y	100%	Tue 12/1/15	Tue 12/1/15		

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4.2.1.1.2	Identify CHEMS standards and certification requirements	Y	100%	Tue 12/1/15	Tue 12/1/15		
4.2.1.1.3	Develop "how-to" guide or coaching manual to address educational needs (ALS)	Y	100%	Tue 12/1/15	Sat 4/30/16		
4.2.1.1.4	Develop "how-to" guide or coaching manual to address educational needs (BLS and ILS)		0%	Tue 1/3/17	Mon 5/1/17		
4.2.1.1.5	**Contract for Community Paramedics (CP)**		**100%**	**Tue 12/1/15**	**Fri 1/1/16**		
4.2.1.1.5.1	Collect best practice resources and policies for program implementation	Y	100%	Tue 12/1/15	Mon 12/28/15		
4.2.1.1.5.2	Identify required training metrics and reporting process for ALS	Y	100%	Fri 1/1/16	Fri 1/1/16		
4.2.1.1.5.3	Execute contract with training vendor to provide CHEMS trainings for community paramedics (ALS)	Y	100%	Fri 1/1/16	Fri 1/1/16		
4.2.1.1.6	**Contract for Emergency Medical Technicians (EMTs)**		**0%**	**Tue 1/3/17**	**Mon 5/1/17**		
4.2.1.1.6.1	Review best practices and resources		0%	Tue 1/3/17	Mon 1/16/17		
4.2.1.1.6.2	Identify required training metrics and reporting process for BLS and ILS		0%	Wed 2/1/17	Mon 5/1/17		
4.2.1.1.6.3	Execute contract with training vendor to provide CHEMS trainings for EMTs (BLS and ILS)		0%	Wed 2/1/17	Mon 5/1/17		
4.2.1.2	**Continuing Education for CHEMS Program**		**0%**	**Wed 2/1/17**	**Thu 1/31/19**		
4.2.1.2.1	**CHEMS Learning Collaborative**		**0%**	**Wed 2/1/17**	**Thu 1/31/19**		
4.2.1.2.1.1	Secure funding		0%	Wed 2/1/17	Mon 2/27/17		
4.2.1.2.1.2	Schedule webinars and in person meeting		0%	Thu 2/16/17	Wed 3/1/17		

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
4.2.1.2.1.3	Secure presenters and develop content		0%	Fri 2/16/18	Thu 3/1/18		
4.2.1.2.1.4	Evaluate outcomes		0%	Fri 12/21/18	Thu 1/31/19		
4.2.1.2.2	**CHEMS Peer Mentoring Program**		**0%**	**Mon 3/20/17**	**Mon 12/31/18**		
4.2.1.2.2.1	Review best practices and resources		0%	Mon 3/20/17	Fri 3/31/17		
4.2.1.2.2.2	Develop peer mentoring program support		0%	Mon 4/3/17	Fri 4/28/17		
4.2.1.2.2.3	Develop coaching material		0%	Thu 4/20/17	Wed 5/31/17		
4.2.1.2.2.4	Identify potential mentors		0%	Thu 5/4/17	Wed 5/31/17		
4.2.1.2.2.5	Secure funding		0%	Mon 5/22/17	Fri 6/30/17		
4.2.1.2.2.6	Establish MOUs		0%	Mon 6/5/17	Fri 7/14/17		
4.2.1.2.2.7	Negotiate contracts with mentors		0%	Thu 4/20/17	Wed 5/31/17		
4.2.1.2.2.8	Finalize contracts with mentors		0%	Mon 6/19/17	Fri 6/30/17		
4.2.1.2.2.9	Execute contracts with mentors		0%	Fri 7/14/17	Fri 7/14/17		
4.2.1.2.2.10	Select recipient agencies		0%	Fri 6/30/17	Fri 6/30/17		
4.2.1.2.2.11	Implement peer mentoring program		0%	Tue 8/1/17	Mon 12/31/18		
4.2.2	**Implement CHEMS Program**		**15%**	**Fri 1/1/16**	**Mon 12/31/18**		
4.2.2.1	**Recruit CHEMS Agencies and Train CHEMS Personnel**		**0%**	**Fri 1/1/16**	**Mon 12/31/18**		
4.2.2.1.1	CP Cohort 1	N	0%	Fri 1/1/16	Fri 12/30/16	Will be completed after submission of the Operational Plan.	
4.2.2.1.2	CP Cohort 2		0%	Mon 1/2/17	Fri 12/29/17		
4.2.2.1.3	CP Cohort 3		0%	Mon 1/1/18	Mon 12/31/18		
4.2.2.1.4	EMT Cohort 1		0%	Thu 6/1/17	Wed 10/18/17		
4.2.2.1.5	EMT Cohort 2		0%	Thu 2/1/18	Wed 6/20/18		

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
4.2.2.2	Establish agreements with CHEMS agencies		0%	Thu 12/1/16	Tue 2/14/17		
4.2.2.3	Develop toolkit for CHEMS agencies for internal and external stakeholder engagement	Y	100%	Wed 6/1/16	Fri 12/30/16		
4.2.2.4	CHEMS Agencies engage stakeholders		20%	Wed 6/1/16	Wed 1/31/18		
4.3	**Telehealth**		**24%**	**Fri 4/1/16**	**Fri 11/3/17**		
4.3.1	Establish Subcommittee of Telehealth Council	Y	100%	Fri 4/1/16	Fri 4/1/16		
4.3.2	Develop telehealth expansion and implementation plan	Y	100%	Fri 4/1/16	Tue 5/31/16		**Determine how telehealth can be expanded in Idaho.**
4.3.3	**Educate SHIP Clinics about the Telehealth Program**		**72%**	**Fri 7/1/16**	**Tue 1/10/17**		**Provide education to SHIP clinics about use of telehealth equipment.**
4.3.3.1	**Secure Telehealth Consultant Contractor**		**100%**	**Fri 7/1/16**	**Fri 8/12/16**		**Procure HIT expertise.**
4.3.3.1.1	Develop RFQ for telehealth consultant	Y	100%	Fri 7/1/16	Fri 7/8/16		
4.3.3.1.2	Release RFQ for telehealth consultant	Y	100%	Mon 7/11/16	Mon 7/11/16		
4.3.3.1.3	Procure telehealth consultant	Y	100%	Tue 7/12/16	Fri 8/12/16		
4.3.3.2	Deliver webinars for primary care clinics	N	60%	Wed 9/28/16	Tue 1/10/17	Will be completed after submission of the Operational Plan.	**Provide training on use and implementation of telehealth equipment.**
4.3.4	**Implement PCMH Telehealth Program**		**5%**	**Tue 11/1/16**	**Tue 6/6/17**		

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
4.3.4.1	**Develop Program Design for PCMH Telehealth**		**14%**	**Tue 11/1/16**	**Mon 12/26/16**		
4.3.4.1.1	**Design Application Process**		**25%**	**Tue 11/1/16**	**Mon 12/26/16**		
4.3.4.1.1.1	Establish criteria for submission of telehealth projects for consideration	Y	100%	Tue 11/1/16	Mon 11/14/16		**Determine requirements for telehealth program.**
4.3.4.1.1.2	Create application and establish evaluation criteria and process	N	0%	Tue 11/15/16	Mon 12/12/16	Will be completed after submission of the Operational Plan.	
4.3.4.1.1.3	Identify evaluation committee members to review applications	N	0%	Tue 12/13/16	Mon 12/26/16	Will be completed after submission of the Operational Plan.	
4.3.4.1.2	Publish PCMH telehealth grant application	N	0%	Mon 12/12/16	Mon 12/12/16	Will be completed after submission of the Operational Plan.	**Publish requirements for telehealth grant application.**
4.3.4.1.3	Develop communication strategy	N	0%	Tue 11/15/16	Mon 12/12/16	Will be completed after submission of the Operational Plan.	
4.3.4.1.4	Develop evaluation plan for PCMH telehealth grant recipients	Y	0%	Tue 11/1/16	Mon 11/14/16		**Establish criteria and process for evaluating use of telehealth equipment.**
4.3.4.2	**Implement PCMH Telehealth Program**		**0%**	**Tue 12/13/16**	**Tue 6/6/17**		
4.3.4.2.1	PCMH Telehealth Program grant application period		0%	Tue 12/13/16	Mon 2/13/17		
4.3.4.2.2	Application review period		0%	Tue 2/14/17	Mon 3/13/17		

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
4.3.4.2.3	Secure funding from CMMI		0%	Tue 3/14/17	Mon 4/24/17		
4.3.4.2.4	Distribute PCMH telehealth grants		0%	Tue 4/25/17	Mon 6/5/17		
4.3.4.2.5	Begin monitoring and managing awarded PCMH telehealth grants		0%	Tue 6/6/17	Tue 6/6/17		**Review data and/or reports about use of telehealth equipment.**
4.3.5	**Implement CHEMS Telehealth Program**		**0%**	**Mon 4/3/17**	**Fri 11/3/17**		
4.3.5.1	**Develop Program Design for CHEMS Telehealth**		**0%**	**Mon 4/3/17**	**Fri 5/26/17**		
4.3.5.1.1	**Design Application Process**		**0%**	**Mon 4/3/17**	**Fri 5/26/17**		
4.3.5.1.1.1	Establish criteria for submission of telehealth projects for consideration		0%	Mon 4/3/17	Fri 4/14/17		
4.3.5.1.1.2	Create application and establish evaluation criteria and process		0%	Mon 4/17/17	Fri 5/12/17		
4.3.5.1.1.3	Identify evaluation committee members to review applications		0%	Mon 5/15/17	Fri 5/26/17		
4.3.5.1.2	Publish CHEMS telehealth grant application		0%	Fri 5/12/17	Fri 5/12/17		**Publish requirements for telehealth grant application.**
4.3.5.1.3	Develop communication strategy		0%	Mon 4/17/17	Fri 5/12/17		
4.3.5.2	Develop evaluation plan for CHEMS telehealth grant recipients		0%	Mon 4/3/17	Fri 4/14/17		**Establish criteria and process for evaluating use of telehealth equipment by CHEMS agencies.**
4.3.5.3	**Implement CHEMS Telehealth Program**		**0%**	**Mon 5/15/17**	**Fri 11/3/17**		
4.3.5.3.1	CHEMS Telehealth Program grant application period		0%	Mon 5/15/17	Fri 7/14/17		
4.3.5.3.2	Application review period		0%	Mon 7/17/17	Fri 8/11/17		

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
4.3.5.3.3	Secure funding from CMMI		0%	Mon 8/14/17	Fri 9/22/17		
4.3.5.3.4	Distribute CHEMS telehealth grants		0%	Mon 9/25/17	Fri 11/3/17		
4.3.5.3.5	Begin monitoring and managing awarded CHEMS telehealth grants		0%	Mon 9/25/17	Mon 9/25/17		**Review data and/or reports about use of telehealth equipment.**
4.4	**Community Health Workers (CHWs)**		**9%**	**Mon 2/1/16**	**Thu 1/31/19**		
4.4.1	**Establish In-State Training Programs for CHW**		**59%**	**Mon 2/1/16**	**Tue 8/15/17**		
4.4.1.1	**Initial CHW Training Program**		**100%**	**Mon 2/1/16**	**Fri 7/8/16**		
4.4.1.1.1	Establish CHW team and identify CHW sub committee leads	Y	100%	Fri 2/26/16	Fri 2/26/16		
4.4.1.1.2	Collect best practice resources and policies for program implementation	Y	100%	Mon 2/1/16	Mon 2/29/16		
4.4.1.1.3	Identify CHW training standards	Y	100%	Tue 3/1/16	Tue 3/29/16		
4.4.1.1.4	Contract with training vendor to provide CHW trainings	Y	100%	Mon 5/2/16	Mon 5/2/16		
4.4.1.1.5	Identify required training metrics and reporting process	Y	100%	Mon 5/2/16	Mon 5/2/16		
4.4.1.1.6	Recruit instructors	Y	100%	Fri 7/8/16	Fri 7/8/16		
4.4.1.2	**CHW Continuing Education for CHWs**		**0%**	**Wed 7/5/17**	**Tue 8/15/17**		
4.4.1.2.1	Explore options for continuing education		0%	Wed 7/5/17	Tue 7/25/17		
4.4.1.2.2	Determine approach		0%	Wed 7/26/17	Tue 8/15/17		
4.4.1.2.3	Implement approach		0%	Tue 8/15/17	Tue 8/15/17		
4.4.2	**Implement CHW Program**		**7%**	**Mon 5/2/16**	**Thu 1/31/19**		
4.4.2.1	**Recruit, Enroll, and Train CHWs**		**20%**	**Mon 5/2/16**	**Mon 12/31/18**		
4.4.2.1.1	Cohort 1	Y	100%	Mon 5/2/16	Fri 12/30/16		
4.4.2.1.2	Cohort 2		0%	Mon 10/3/16	Wed 5/31/17		
4.4.2.1.3	Cohort 3		0%	Mon 5/1/17	Fri 12/29/17		

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
4.4.2.1.4	Cohort 4		0%	Mon 10/2/17	Thu 5/31/18		
4.4.2.1.5	Cohort 5		0%	Tue 5/1/18	Mon 12/31/18		
4.4.2.2	**Deploy ISU-Trained CHWs**		**0%**	**Mon 1/2/17**	**Thu 1/31/19**		
4.4.2.2.1	Cohort 1		0%	Mon 1/2/17	Thu 1/31/19		
4.4.2.2.2	Cohort 2		0%	Thu 6/1/17	Thu 1/31/19		
4.4.2.2.3	Cohort 3		0%	Mon 1/1/18	Thu 1/31/19		
4.4.2.2.4	Cohort 4		0%	Fri 6/1/18	Thu 1/31/19		
4.4.2.2.5	Cohort 5		0%	Tue 1/1/19	Thu 1/31/19		
5	**Idaho SHIP Data Analytics**		**10%**	**Mon 2/22/16**	**Wed 1/30/19**		**Provide access to clinical quality measure reports to support care delivery and payment transformation.**
5.1	**Project Initiation/Obtain Contract Approval**		**100%**	**Mon 2/22/16**	**Mon 2/22/16**		
5.2	**Project Management**		**33%**	**Mon 2/22/16**	**Fri 1/4/19**		**Establish project management process.**
5.2.1	Provide project management support		33%	Mon 2/22/16	Fri 1/4/19		
5.2.2	Monitor and control project		33%	Mon 3/7/16	Tue 1/1/19		
5.2.3	Conduct weekly team meetings		33%	Mon 3/7/16	Tue 1/1/19		
5.2.4	Conduct quarterly executive meeting		33%	Wed 7/13/16	Wed 10/10/18		
5.3	**Support Management**		**10%**	**Fri 9/30/16**	**Mon 12/31/18**		
5.3.1	Provide training support		10%	Fri 9/30/16	Mon 12/31/18		
5.3.2	Provide quality assurance support		10%	Fri 9/30/16	Mon 12/31/18		
5.3.3	Provide data analytics support		10%	Fri 9/30/16	Mon 12/31/18		
5.3.4	Provide business analyst support		10%	Fri 9/30/16	Mon 12/31/18		
5.3.5	Provide security support		10%	Fri 9/30/16	Mon 12/31/18		
5.3.6	Provide help desk support		10%	Fri 9/30/16	Mon 12/31/18		

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5.3.7	Provide operational support		10%	Fri 9/30/16	Mon 12/31/18		
5.4	**Planning Phase**		**100%**	**Mon 2/22/16**	**Fri 5/20/16**		
5.4.1	Secure project resources	Y	100%	Tue 2/23/16	Wed 2/24/16		
5.4.2	Conduct project kickoff	Y	100%	Thu 2/25/16	Thu 2/25/16		
5.4.3	Project management plan (30 days)	Y	100%	Mon 2/22/16	Fri 3/18/16		
5.4.4	Project work plan (30 days)	Y	100%	Mon 2/22/16	Fri 3/18/16		
5.4.5	Disaster recovery plan (30 days)	Y	100%	Mon 2/22/16	Fri 3/18/16		**Define plan of action to recover HIT capabilities after a disaster.**
5.4.6	Architectural design model (60 days)	Y	100%	Mon 2/22/16	Fri 4/15/16		**Illustrate the flow of data from data source to data analytics vendor and the flow of information and reports back to the data source (provider).**
5.4.7	Requirements traceability (60 days)	Y	100%	Mon 2/22/16	Wed 4/20/16		**Define requirements for data collection, analysis, and reporting.**
5.4.8	Training plan (60 days)	Y	100%	Mon 2/22/16	Wed 4/20/16		**Identify training requirements for end users (data sources/providers).**
5.4.9	System security plan (30 days)	Y	100%	Mon 2/22/16	Fri 3/18/16		**Develop plan for establishing and maintaining a secure environment for data and reports.**

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5.4.10	Transition plan (90 days)	Y	100%	Mon 2/22/16	Fri 5/20/16		**Develop plan for transfer of project archives and responsibilities.**
5.5	**Support Plans**		**100%**	**Thu 4/21/16**	**Mon 8/1/16**		
5.5.1	Develop support/service management plan	Y	100%	Thu 4/21/16	Wed 6/1/16		**Develop plan for supporting end users with data analytics reports.**
5.5.2	Develop quality assurance plan	Y	100%	Thu 4/21/16	Wed 5/25/16		**Develop plan to assure and control quality of data analytics reporting.**
5.5.3	Plan help desk support	Y	100%	Tue 7/12/16	Mon 8/1/16		**Establish support mechanism.**
5.6	**End User Training**		**18%**	**Tue 7/12/16**	**Wed 1/30/19**		
5.6.1	Plan training	Y	100%	Tue 7/12/16	Wed 11/30/16		**Plan training for end users including development of training requirements, materials, and schedule.**
5.6.2	Create users in TRAINING	N	30%	Wed 8/10/16	Thu 12/8/16	Will be completed after submission of the Operational Plan.	**Create log-in information for end users to access training program.**
5.6.3	Conduct AY2 training per training plan	N	30%	Fri 9/30/16	Tue 1/31/17	Will be completed after submission of the Operational Plan.	**Train end users according to training plan.**

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5.6.4	Conduct AY3 training per training plan		0%	Wed 2/1/17	Wed 1/31/18		**Train end users according to training plan.**
5.6.5	Conduct AY4 training per training plan		0%	Thu 2/1/18	Wed 1/30/19		**Train end users according to training plan.**
5.7	**CQM Reporting**		**2%**	**Mon 2/22/16**	**Mon 12/31/18**		**Develop system to analyze data and produce reports for end users.**
5.7.1	**CQM Reporting AY2**		**4%**	**Mon 2/22/16**	**Fri 12/30/16**		**Develop reporting infrastructure for measures that SHIP cohort clinics must report in the first year of participation.**
5.7.1.1	**Environment Setup and Config (Dev, Test, Prod, Train)**		**100%**	**Mon 2/22/16**	**Fri 6/3/16**		
5.7.1.1.1	Configure application and web servers	Y	100%	Mon 4/4/16	Mon 5/2/16		**Establish environment for end users.**
5.7.1.2	**Iteration 1 (Measure 1)**		**0%**	**Mon 2/22/16**	**Fri 1/27/16**		**Develop reporting infrastructure for measures that SHIP cohort clinics must report in the first year of participation.**
5.7.1.2.1	**Requirements Phase**		**50%**	**Fri 4/8/16**	**Mon 11/08/16**		
5.7.1.2.1.1	**Design and Develop Phase**		**50%**	**Fri 4/8/16**	**Mon 11/08/16**		
5.7.1.2.1.1.1	**Design and Develop ETL Process**		**95%**	**Fri 4/8/16**	**Mon 11/08/16**		

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5.7.1.2.1.1.1.1	CQM proof of concept data	N	32%	Fri 5/6/16	Mon 7/11/16	Will be completed after submission of the Operational Plan.	**Develop prototype of Measure 1 output.**
5.7.1.2.1.2	Peer test ETL process	N	59%	Tue 7/12/16	Fri 9/29/16	Will be completed after submission of the Operational Plan.	**Test process of pulling data and loading into data warehouse.**
5.7.1.2.1.3	Design and develop analytics reports	N	59%	Tue 7/12/16	Mon 9/25/16	Will be completed after submission of the Operational Plan.	**Develop analytics reports for end users.**
5.7.1.2.1.4	Peer test analytics reports	N	59%	Tue 7/26/16	Fri 9/29/16	Will be completed after submission of the Operational Plan.	**Review and refine data analytics reports.**
5.7.1.2.1.5	Design and develop self-service portal	Y	100%	Tue 7/26/16	Fri 10/29/16		**Establish portal for end users to access data analytics reports.**
5.7.1.2.1.6	QA develop test case activities	N	77%	Tue 7/12/16	Mon 11/8/16	Will be completed after submission of the Operational Plan.	
5.7.1.2.2	**Testing - Iteration 1**		**18%**	**Mon 7/18/16**	**Fri 9/23/16**		
5.7.1.2.2.1	User security setup and administration	N	30%	Mon 7/18/16	Fri 9/9/16	Will be completed after submission of the Operational Plan.	**Prepare environment for testing data analytics reports.**
5.7.1.2.2.2	Prepare UAT for testing	Y	100%	Mon 8/8/16	Fri 9/23/16		**Prepare environment for testing data analytics reports.**

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5.7.1.2.2.3	Conduct UAT	N	0%	Mon 8/8/16	Fri 9/23/16	Will be completed after submission of the Operational Plan.	**Test data analytics reports prior to releasing to end users.**
5.7.1.2.3	**Deployment - Iteration 1**		**0%**	**Mon 9/26/16**	**Fri 12/30/16**	W	
5.7.1.2.3.1	Prepare and rollout PROD	N	0%	Mon 9/26/16	Thu 11/29/16		
5.7.1.2.3.2	Go Live Year 1 Measure 1	N	0%	Fri 9/30/16	Fri 12/30/16		**Conduct data analysis and make data analytics reports available to end users through the portal.**
5.7.1.2.3.3	D: Year 1 Measure 1 - Iteration 1		0%	Fri 9/30/16	Fri 12/30/16		
5.7.1.2.4	Technical documentation		0%	Tue 7/12/16	Fri 12/30/16		**Finalize documentation for Measure 1.**
5.7.1.2.5	**Iteration Close Out**		**0%**	**Fri 12/30/16**	**Fri 1/27/16**		
5.7.1.2.5.1	Conduct lessons learned - Year 1, Iteration 1		0%	Fri 12/30/16	Fri 1/27/16	Will be completed after submission of the Operational Plan.	**Discuss successes and opportunities related to implementation of data analytics for Measure 1.**
5.7.1.3	**Iteration 2 (Measure 2)**		**100%**	**Mon 2/22/16**	**Fri 1/27/16**		**Develop reporting infrastructure for measures that SHIP cohort clinics must report in the first year of participation.**
5.7.1.3.1	**Requirements Phase**		**100%**	**Fri 4/8/16**	**Mon 11/08/16**		
5.7.1.3.1.1	**Design and Develop Phase**		**95%**	**Fri 4/8/16**	**Mon 11/08/16**		

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5.7.1.3.1.1.1	**Design and Develop ETL Process**		32%	**Fri 4/8/16**	**Mon 11/08/16**		
5.7.1.3.1.1.1.1	CQM proof of concept data	N	59%	Fri 5/6/16	Mon 7/11/16	Will be completed after submission of the Operational Plan.	**Develop prototype of Measure 2 output.**
5.7.1.3.1.2	Peer test ETL process	N	59%	Tue 7/12/16	Fri 9/29/16	Will be completed after submission of the Operational Plan.	**Test process of pulling data and loading into data warehouse.**
5.7.1.3.1.3	Design and develop analytics reports	N	59%	Tue 7/12/16	Mon 9/25/16	Will be completed after submission of the Operational Plan.	**Develop analytics reports for end users.**
5.7.1.3.1.4	Peer test analytics reports	Y	100%	Tue 7/26/16	Fri 9/29/16		**Review and refine data analytics reports.**
5.7.1.3.1.5	QA develop test case activities	N	77%	Tue 7/26/16	Fri 10/29/16	Will be completed after submission of the Operational Plan.	
5.7.1.3.2	**Testing - Iteration 2**		**18%**	Tue 7/12/16	Mon 11/8/16		
5.7.1.3.2.1	User security setup and administration	N	30%	**Mon 7/18/16**	**Fri 9/23/16**	Will be completed after submission of the Operational Plan.	**Prepare environment for testing data analytics reports.**
5.7.1.3.2.2	Prepare UAT for testing	Y	100%	Mon 7/18/16	Fri 9/9/16		**Prepare environment for testing data analytics reports.**

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
5.7.1.3.2.3	Conduct UAT	N	0%	Mon 8/8/16	Fri 9/23/16	Will be completed after submission of the Operational Plan.	**Test data analytics reports prior to releasing to end users.**
5.7.1.3.3	**Deployment - Iteration 2**		**0%**	Mon 8/8/16	Fri 9/23/16		
5.7.1.3.3.1	Prepare and rollout PROD	N	0%	**Mon 9/26/16**	**Fri 12/30/16**	Will be completed after submission of the Operational Plan.	**Activate user log-in for production environment.**
5.7.1.3.3.2	Go Live Year 1 Measure 2	N	0%	Mon 9/26/16	Thu 11/29/16	Will be completed after submission of the Operational Plan.	**Conduct data analysis and make data analytics reports available to end users through the portal.**
5.7.1.3.3.3	D: Year 1 Measure 2 - Iteration 2	N	0%	Fri 9/30/16	Fri 12/30/16	Will be completed after submission of the Operational Plan.	
5.7.1.3.4	Technical documentation		0%	Fri 9/30/16	Fri 12/30/16	Will be completed after submission of the Operational Plan.	**Finalize documentation for Measure 2.**
5.7.1.3.5	**Iteration Close Out**	N	**0%**	Tue 7/12/16	Fri 12/30/16	Will be completed after submission of the Operational Plan.	
5.7.1.3.5.1	Conduct lessons learned - Year 1, Iteration 2		0%	**Fri 12/30/16**	**Fri 1/27/16**		**Discuss successes and opportunities related to implementation of data analytics for Measure 2.**

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
5.7.1.4	**Iteration 3 (Measure 3)**		**0%**	**Mon 2/22/16**	**Fri 1/27/16**		**Develop reporting infrastructure for measures that SHIP cohort clinics must report in the first year of participation.**
5.7.1.4.1	Requirements phase	Y	**100%**	**Fri 4/8/16**	**Mon 11/08/16**		
5.7.1.4.2	**Design and Develop Phase**	Y	**100%**	**Fri 4/8/16**	**Mon 11/08/16**		
5.7.1.4.2.1	**Design and Develop ETL Process**		**95%**	**Fri 4/8/16**	**Mon 11/08/16**		
5.7.1.4.2.1.1	CQM proof of concept data	N	32%	Fri 5/6/16	Mon 7/11/16	Will be completed after submission of the Operational Plan.	**Develop prototype of Measure 3 output.**
5.7.1.4.2.2	Peer test ETL process	N	59%	Tue 7/12/16	Fri 9/29/16	Will be completed after submission of the Operational Plan.	**Test process of pulling data and loading into data warehouse.**
5.7.1.4.2.3	Design and develop analytics reports	N	59%	Tue 7/12/16	Mon 9/25/16	Will be completed after submission of the Operational Plan.	**Develop analytics reports for end users.**
5.7.1.4.2.4	Peer test analytics reports	N	59%	Tue 7/26/16	Fri 9/29/16	Will be completed after submission of the Operational Plan.	**Review and refine data analytics reports.**
5.7.1.4.2.5	QA develop test case activities	Y	100%	Tue 7/26/16	Fri 10/29/16		
5.7.1.4.3	**Testing - Iteration 3**		77%	Tue 7/12/16	Mon 11/8/16		
5.7.1.4.3.1	User security setup and administration	N	**18%**	**Mon 7/18/16**	**Fri 9/23/16**	Will be completed after submission of the Operational Plan.	**Prepare environment for testing data analytics reports.**

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
5.7.1.4.3.2	Prepare UAT for testing	N	30%	Mon 7/18/16	Fri 9/9/16	Will be completed after submission of the Operational Plan.	**Prepare environment for testing data analytics reports.**
5.7.1.4.3.3	Conduct UAT	Y	100%	Mon 8/8/16	Fri 9/23/16		**Test data analytics reports prior to releasing to end users.**
5.7.1.4.4	**Deployment - Iteration 3**		0%	Mon 8/8/16	Fri 9/23/16		
5.7.1.4.4.1	**Prepare and Rollout PROD**		**0%**	**Mon 9/26/16**	**Fri 12/30/16**		
5.7.1.4.4.1.1	Create users in PROD	N	0%	Mon 9/26/16	Thu 11/29/16	Will be completed after submission of the Operational Plan.	**Activate user log-in for production environment.**
5.7.1.4.4.2	Go Live Year 1 Measure 3	N	0%	Fri 9/30/16	Fri 12/30/16	Will be completed after submission of the Operational Plan.	**Conduct data analysis and make data analytics reports available to end users through the portal.**
5.7.1.4.4.3	D: Year 1 Measure 3 - Iteration 3	N	0%	Fri 9/30/16	Fri 12/30/16	Will be completed after submission of the Operational Plan.	
5.7.1.4.5	Technical documentation	N	0%	Tue 7/12/16	Fri 12/30/16	Will be completed after submission of the Operational Plan.	**Finalize documentation for Measure 3.**
5.7.1.4.6	**Iteration Close Out**	N	**0%**	**Fri 12/30/16**	**Fri 1/27/16**		

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
5.7.1.4.6.1	Conduct lessons learned - Year 1, Iteration 3	N	0%	Fri 12/30/16	Fri 1/27/16	Will be completed after submission of the Operational Plan.	**Discuss successes and opportunities related to implementation of data analytics for Measure 3.**
5.7.1.5	**Iteration 4 (Measure 4)**		**0%**	**Mon 2/22/16**	**Fri 1/27/16**		**Develop reporting infrastructure for measures that SHIP cohort clinics must report in the first year of participation.**
5.7.1.5.1	Requirements phase		**100%**	**Fri 4/8/16**	**Mon 11/08/16**		
5.7.1.5.2	**Design and Develop Phase**		**100%**	**Fri 4/8/16**	**Mon 11/08/16**		
5.7.1.5.2.1	**Design and Develop ETL Process**		**95%**	**Fri 4/8/16**	**Mon 11/08/16**		
5.7.1.5.2.1.1	CQM proof of concept data	N	32%	Fri 5/6/16	Mon 7/11/16	Will be completed after submission of the Operational Plan.	**Develop prototype of Measure 4 output.**
5.7.1.5.2.2	Peer test ETL process	N	59%	Tue 7/12/16	Fri 9/29/16	Will be completed after submission of the Operational Plan.	**Test process of pulling data and loading into data warehouse.**
5.7.1.5.2.3	Design and develop analytics reports	N	59%	Tue 7/12/16	Mon 9/25/16	Will be completed after submission of the Operational Plan.	
5.7.1.5.2.4	Peer test analytics reports	N	59%	Tue 7/26/16	Fri 9/29/16	Will be completed after submission of the Operational Plan.	
5.7.1.5.2.5	QA develop test case activities	Y	100%	Tue 7/26/16	Fri 10/29/16		

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
5.7.1.5.3	**Testing - Iteration 4**		77%	Tue 7/12/16	Mon 11/8/16		
5.7.1.5.3.1	User security setup and administration	N	**18%**	**Mon 7/18/16**	**Fri 9/23/16**	Will be completed after submission of the Operational Plan.	**Prepare environment for testing data analytics reports.**
5.7.1.5.3.2	Prepare UAT for testing	N	30%	Mon 7/18/16	Fri 9/9/16	Will be completed after submission of the Operational Plan.	**Prepare environment for testing data analytics reports.**
5.7.1.5.3.3	Conduct UAT	Y	100%	Mon 8/8/16	Fri 9/23/16		**Test data analytics reports prior to releasing to end users.**
5.7.1.5.4	**Deployment - Iteration 4**		0%	Mon 8/8/16	Fri 9/23/16		
5.7.1.5.4.1	**Prepare and Rollout PROD**		**0%**	**Mon 9/26/16**	**Fri 12/30/16**		
5.7.1.5.4.1.1	Create users in PROD	N	0%	Mon 9/26/16	Thu 11/29/16	Will be completed after submission of the Operational Plan.	**Activate user log-in for production environment.**
5.7.1.5.4.2	Go Live Year 1 Measure 4	N	0%	Fri 9/30/16	Fri 12/30/16	Will be completed after submission of the Operational Plan.	**Conduct data analysis and make data analytics reports available to end users through the portal.**
5.7.1.5.4.3	D: Year 1 Measure 4 - Iteration 4	N	0%	Fri 9/30/16	Fri 12/30/16	Will be completed after submission of the Operational Plan.	
5.7.1.5.5	Technical documentation		0%	Tue 7/12/16	Fri 12/30/16		**Finalize documentation for Measure 4.**

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
5.7.1.5.6	Iteration close out	N	**0%**	**Fri 12/30/16**	**Fri 1/27/16**	Will be completed after submission of the Operational Plan.	**Discuss successes and opportunities related to implementation of data analytics for Measure 4.**
5.7.2	**CQM Reporting AY3**		**0%**	**Tue 12/27/16**	**Fri 12/29/17**		
5.7.2.1	Iteration 5 (Measure 5)		0%	Tue 12/27/16	Fri 3/31/17		**Develop reporting infrastructure for measures that SHIP cohort clinics must report in the second year of participation.**
5.7.2.2	Iteration 6 (Measure 6)		0%	Mon 4/3/17	Wed 5/31/17		**Develop reporting infrastructure for measures that SHIP cohort clinics must report in the second year of participation.**
5.7.2.3	Iteration 7 (Measure 7)		0%	Thu 5/25/17	Mon 7/31/17		**Develop reporting infrastructure for measures that SHIP cohort clinics must report in the second year of participation.**
5.7.2.4	Iteration 8 (Measure 8)		0%	Tue 7/25/17	Fri 9/29/17		**Develop reporting infrastructure for measures that SHIP cohort clinics must report in the second year of participation.**

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
5.7.2.5	Iteration 9 (Measure 9)		0%	Mon 9/25/17	Thu 11/30/17		**Develop reporting infrastructure for measures that SHIP cohort clinics must report in the second year of participation.**
5.7.2.6	Iteration 10 (Measure 10)		0%	Fri 11/24/17	Fri 12/29/17		**Develop reporting infrastructure for measures that SHIP cohort clinics must report in the second year of participation.**
5.7.3	**CQM Reporting AY4**		**0%**	**Fri 12/29/17**	**Mon 12/31/18**		
5.7.3.1	Iteration 11 (Measure 11)		0%	Fri 12/29/17	Fri 3/30/18		**Develop reporting infrastructure for measures that SHIP cohort clinics must report in the third year of participation.**
5.7.3.2	Iteration 12 (Measure 12)		0%	Wed 3/28/18	Fri 5/25/18		**Develop reporting infrastructure for measures that SHIP cohort clinics must report in the third year of participation.**
5.7.3.3	Iteration 13 (Measure 13)		0%	Mon 5/21/18	Mon 7/30/18		**Develop reporting infrastructure for measures that SHIP cohort clinics must report in the third year of participation.**

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
5.7.3.4	Iteration 14 (Measure 14)		0%	Tue 7/24/18	Fri 9/28/18		**Develop reporting infrastructure for measures that SHIP cohort clinics must report in the third year of participation.**
5.7.3.5	Iteration 15 (Measure 15)		0%	Mon 9/24/18	Fri 11/30/18		**Develop reporting infrastructure for measures that SHIP cohort clinics must report in the third year of participation.**
5.7.3.6	Iteration 16 (Measure 16)		0%	Mon 11/26/18	Mon 12/31/18		**Develop reporting infrastructure for measures that SHIP cohort clinics must report in the third year of participation.**
5.8	**Project Closeout**		**0%**	**Mon 12/31/18**	**Fri 1/4/19**		
5.8.1	Develop project closeout report		0%	Mon 12/31/18	Mon 12/31/18		
5.8.2	Confirm project artifacts are in SharePoint		0%	Tue 1/1/19	Tue 1/1/19		**Archive project documentation.**
5.8.3	Finalize and closeout project		0%	Wed 1/2/19	Fri 1/4/19		
6	**Test Transformation from Fee-for-Service to Value-Based Payments**		**72%**	**Sun 3/1/15**	**Thu 2/28/19**		
6.1	**Develop Alternative Payment Methods**		**100%**	**Sun 3/1/15**	**Mon 8/31/15**		
6.1.1	Determine alternative value based payment methodologies by payer	Y	100%	Sun 3/1/15	Mon 8/31/15		
6.1.2	Determine member attribution method	Y	100%	Sun 3/1/15	Mon 8/31/15		**Develop attribution report that will be used in data analytics.**

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
6.1.3	Determine reimbursment payments	Y	100%	Sun 3/1/15	Mon 8/31/15		
6.1.4	Determine quality measures	Y	100%	Sun 3/1/15	Mon 8/31/15		
6.2	**Contract with PCMHs and Primary Care Providers**		**39%**	**Sun 11/1/15**	**Thu 1/31/19**		
6.2.1	Pre-testing phase reporting	Y	100%	Sun 11/1/15	Mon 11/30/15		
6.2.2	AY2	Y	100%	Fri 1/1/16	Sat 1/30/16		
6.2.3	AY3	N	0%	Sun 1/1/17	Tue 1/31/17	Will be completed after submission of the Operational Plan.	
6.2.4	AY4		0%	Mon 1/1/18	Wed 1/31/18		
6.2.5	Year 5		0%	Tue 1/1/19	Thu 1/31/19		
6.3	**Attribute Membership**		**39%**	**Tue 9/1/15**	**Thu 2/28/19**		
6.3.1	Pre-testing phase reporting	Y	100%	Sun 11/1/15	Mon 11/30/15		
6.3.2	AY2	Y	100%	Fri 1/1/16	Sat 1/30/16		
6.3.3	AY3	N	0%	Sun 1/1/17	Tue 1/31/17	Will be completed after submission of the Operational Plan.	
6.3.4	AY4		0%	Mon 1/1/18	Wed 1/31/18		
6.3.5	Year 5		0%	Tue 1/1/19	Thu 1/31/19		
6.4	**Track and Report Payments and Costs**		**50%**	**Tue 9/1/15**	**Thu 2/28/19**		
6.4.1	Pre-testing phase reporting	Y	100%	Sun 11/1/15	Mon 11/30/15		
6.4.2	AY2	N	60%	Fri 1/1/16	Wed 11/30/16	Waiting on information from payers.	
6.4.3	AY3		0%	Sun 1/1/17	Tue 1/31/17		
6.4.4	AY4		0%	Mon 1/1/18	Wed 1/31/18		
6.4.5	Year 5		0%	Tue 1/1/19	Thu 1/31/19		
7	**Cost Savings and Return on Investment Model**		**40%**	**Mon 6/1/15**	**Thu 1/31/19**		

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
7.1	**Create Data Request**		**37%**	**Mon 6/1/15**	**Thu 1/31/19**		
7.1.1	Determine minimum reporting requirements for projections	Y	100%	Mon 6/1/15	Fri 7/31/15		
7.1.2	Gather data specifications for categories of service	Y	100%	Wed 7/1/15	Fri 7/31/15		
7.1.3	Distribute request and client confidentiality agreements	Y	100%	Wed 7/1/15	Fri 7/31/15		
7.1.4	Legal review of client confidentiality agreement changes		33%	Wed 7/1/15	Thu 1/31/19		**Establish permission to exchange data.**
7.1.5	Create connect site for payers to drop data	Y	100%	Tue 9/1/15	Wed 9/30/15		**Create a secure data exchange environment for payers.**
7.1.6	Find historical data as contingency for Medicare FFS and self-insured data	Y	100%	Tue 9/1/15	Sat 10/31/15		
7.1.7	Create CMS data request for Medicare FFS data		33%	Wed 7/1/15	Thu 1/31/19		
7.1.8	Informatics and legal review of CMS data request	Y	33%	Tue 9/1/15	Thu 1/31/19		
7.2	**Create Financial Analysis Report Template**		**100%**	**Tue 9/1/15**	**Mon 11/30/15**		
7.2.1	Create Excel template to collect payer data, accumulate it, and calculate base rate PMPMs	Y	100%	Tue 9/1/15	Sat 10/31/15		
7.2.2	Determine trend/CPI to use for projecting data	Y	100%	Thu 10/1/15	Sat 10/31/15		
7.2.3	Verify and update cost saving assumptions	Y	100%	Tue 9/1/15	Sat 10/31/15		
7.2.4	Apply cost savings to intervention model	Y	100%	Thu 10/1/15	Mon 11/30/15		
7.2.5	Compare baseline model to intervention model	Y	100%	Sun 11/1/15	Mon 11/30/15		

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Outline Number	Task Name	Task Completed (Y/N)	% Complete	Start	Finish	Reason for Incomplete Task	Health IT Activity Supporting the SIM Component
7.3	**Develop Financial Analysis Report**		**33%**	**Sun 11/1/15**	**Thu 11/30/17**		
7.3.1	Create financial analysis report for AY1	Y	100%	Sun 11/1/15	Mon 11/30/15		
7.3.2	Create financial analysis report for AY2		0%	Tue 11/1/16	Wed 11/30/16		
7.3.3	Create financial analysis report for AY3		0%	Wed 11/1/17	Thu 11/30/17		

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B.State Innovation Model (SIM) Policy and Operational Areas

B.1. SIM Governance

In award year 3 (AY3) Idaho will continue to implement activities and strategies that will ultimately lead to achievement of all seven transformational goals. The Idaho Healthcare Coalition (IHC) will continue to guide and monitor all activities across the seven goals.

In 2016, Governor Otter reaffirmed the role of the IHC in Idaho's healthcare system transformation by issuing Executive Order 2016-02[8], which extended the effective date of Executive Order 2014-02 (establishing the role of the IHC) for three years. The new executive order also sets a direction for AY3 and onward by committing to transform the state's healthcare system not through regulatory and legislative mandates, but through public-private leadership and stakeholder engagement under the guidance of the IHC. In fact, no specific legislative or regulatory action related to healthcare transformation is being considered for AY3 at this time. This may be revisited in AY4 based on IHC recommendations to the governor for sustainability.

To fulfill its responsibility of overseeing policy and operational areas related to Idaho's seven goals, in AY3 the IHC will continue to review its membership to ensure diverse and broad stakeholder participation in the state's overall transformation and SHIP activities specifically. At the start of AY3, the IHC will have 48 members, having expanded the group's representation of subject matter expertise, geographic diversity, and broad healthcare system perspectives.

The four new members to the group appointed by Governor Otter are: Kathy Brashear of Alliance Title Team, Pam Catt-Oliason from the Idaho Commission on Aging, Janica Hardin from the Saint Alphonsus Medical Group, and Katherine Hansen of Community Partnerships of Idaho.

Other changes in IHC membership that occurred in AY2 and that will impact AY3 include the retirement of Denise Chuckovich as the Idaho Department of Health and Welfare (IDHW) Deputy Director and IHC Co-Chair in May 2016. At that time, Lisa Hettinger, the former Division of Medicaid Administrator and IHC member, was named the new IDHW Deputy Director and IHC Co-Chair. Matt Wimmer, former Deputy Administrator for Medicaid, became the new Division of Medicaid Administrator and a member of the IHC. The IHC also named Mr. Wimmer as the co-chair of the Idaho Medical Home Collaborative (IMHC). Both Ms. Hettinger and Mr. Wimmer will continue to serve in their respective capacities in AY3.

The IDHW SHIP team will continue to oversee SHIP day-to-day operations in AY3 and ensure that the IHC, the Governor's office, state legislators, and other stakeholders are apprised of the Model's progress. The IDHW SHIP team for AY3 will be comprised of the staff listed below:

[8] https://gov.idaho.gov/mediacenter/execorders/eo16/EO_2016-02.pdf

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Table 1 – AY3 IDHW SHIP Team

IDHW SHIP Team Positions	
Cynthia York	SHIP Administrator
Casey Moyer	Operations Project Manager
Ann Watkins	Grants and Contract Officer
Kymberlee Schreiber	Patient-centered Medical Home (PCMH) Transformation Project Manager
Burke Jensen	Health IT Project Manager
Miro Barac	Regional Health Collaborative (RC) and Virtual PCMH Project Manager
Taylor Kaserman	Administrative Assistant 2
Alexa Wilson	Administrative Assistant 2
Stacey St. Amand (.5 FTE)	Communications Specialist

The current RC and Virtual PCMH Project Manager will be leaving this position at the end of November 2016; in by the start of AY3, a new project manager will be recruited to fill this position.

In AY2, the Department expanded the IDHW SHIP team to include a part-time Communications Specialist. This position is responsible for creating, editing, and expediting communications messages and materials related to SHIP. The Specialist will help ensure that communications about the project are disseminated in a timely manner and are appropriately targeted to different audiences. This position will be housed in the Office of Healthcare Policy Initiatives.

In addition to this new SHIP position, the Office of Healthcare Policy Initiatives developed a partnership with SIM State Evaluator to allow graduate students to support the IDHW SHIP team as graduate research assistants and one undergraduate research assistant. Their continued efforts in this capacity during AY3 will serve as a valuable learning and career development experience for the interns and will also support the IDHW SHIP team's overall implementation of the Model.

In AY2, IDHW completed the procurement process for the Telehealth Technical Assistance Contractor (Health Management Associates), technical assistance for community health emergency medical services (CHEMS) agencies (Ada County Paramedics), the Statewide Data Analytics Contractor (HealthTech Solutions), and the State Evaluator (University of Idaho). These contractors will continue to support SHIP activities in AY3 and relationships will be renewed following evaluation of successful performance and according to their respective annual contracting timelines. IDHW does not anticipate any further procurement in AY3.

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Table 2 – AY3 SHIP Contractors

AY3 SHIP Contractors and Role	
Mercer	Project management and financial analysis
Briljent	PCMH transformation Briljent subcontracts with: 1. Health Management Associates (HMA) to provide PCMH technical assistance in the transformation process 2. Myers and Stauffer to manage the PCMH reimbursment(s) and development of the portal dashboard Briljent also executes agreements with the primary care clinics selected for a SHIP cohort
HealthTech Solutions (HTS)	Data analytics
Idaho Health Data Exchange (IHDE)	Health information exchange (HIE) including data aggregation and cleansing
University of Idaho	State Evaluator University of Idaho subcontracts with Boise State University
HMA	Telehealth technical assistance
IDHW's Public Health Districts (PHDs)	Support for primary care clinics selected for a SHIP cohort and support for RCs
KMP	Data element mapping
Invoked Health, LLC	Statewide Health Information Technology (HIT) plan
Idaho State University	Community health worker (CHW) training
CHEMS Agencies	Build CHEMS programs in the community
Viann Electronics	Population health data analytics for the Division of Public Health
Ada County Paramedics	Technical assistance support for SHIP CHEMS agencies
Telehealth Grant Recipients	Implement use of telehealth equipment to deliver care

Additional information regarding Idaho's operations monitoring structure, including the approach to managing contractors, can be found in Section D.3 (Program Monitoring and Reporting).

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B.2. Stakeholder Engagement and Communications

Positive and successful health transformation begins with active stakeholder engagement. Throughout AY2, Idaho has continued to foster collaborative partnerships with stakeholders across public and private sectors. Idaho believes its most important principle, and the key to the state's success thus far, is the value and commitment it places on a stakeholder-led process. Words such as "stakeholder-driven" and "partnership", which are echoed by so many states, have real meaning and action in Idaho.

Idaho's strong commitment to stakeholder engagement will continue in AY3.

Developing Communications Materials

In AY2, the IHC oversaw the implementation of Idaho's Communications Plan (described in the 2015 Operational Plan), including the development of a communications toolkit with materials specific to each stakeholder audience. By centralizing the development of communications materials, Idaho was able to ensure that materials are consistent, accurate, and contain effective messages to sustain interest, education, and active participation of stakeholders in SHIP.

In AY3, the IHC will add to its communication toolkit, which now consists of the following materials:

- Key messages for:
  - Patients
  - Primary care providers (PCPs) that are SHIP clinics
  - PCPs that are potential SHIP clinics
  - Medical-Health Neighborhood participants
  - RCs
  - Policy makers
- SHIP educational PowerPoint presentations for:
  - Engaged PCPs
  - Policy makers
  - Potential PCPs
  - RCs
- A SHIP clinic patient brochure in English and Spanish
- A fact sheet for healthcare professionals that explains the components of a Virtual PCMH

The schedule for development of communication materials in AY3 is intended to be flexible in order to respond to stakeholders' needs. It is anticipated that the communication materials to be developed in AY3 will focus on building the Medical-Health Neighborhood, establishing Virtual PCMHs, and strengthening the role of the RCs. Examples of additions to the communication toolkit include a Medical-Health Neighborhood fact sheet to recruit specialists and community partners' participation in SHIP, and district-specific materials for use by RC members to recruit participation in SHIP at the local level.

Implementing and Monitoring Communications

The process currently in place to track when communications materials are being used and to obtain feedback on stakeholders' perceptions of the usefulness and effectiveness of the materials will be followed in AY3.

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The IDHW SHIP team will continue to regularly update the SHIP website (www.ship.idaho.gov) with the most recent information about the Model Test, including IHC and workgroup meeting minutes, a map showing locations of SHIP clinics, the SHIP interest survey and final PCMH application, resources for SHIP clinics, and copies of communications materials.

The IDHW SHIP team will also continue its focus on frequent and robust communications to internal stakeholders, principally its contractors and the SHIP cohort clinics. Communications will include updates on Model Test implementation, and, for clinics, the areas of connection to IHDE, data reporting, and training and technical assistance available through HMA and the PHD SHIP staff.

In AY3, the Communications Specialist will provide important support to the communications aspects of the Model Test. The Communications Specialist will assist with the development of communications messages and materials (described above), and monitoring how communications are implemented. As needed, the Communications Specialist will work with the IDHW SHIP team and the IHC to revise materials and the communications process to improve the effectiveness of communications. The communication plan will be revised accordingly.

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B.3. Goal 1: Transform primary care clinics across the State into PCMHs.

Idaho's healthcare system transformation establishes the PCMH model as the foundation for primary care services for Idahoans, integrated within the local Medical-Health Neighborhood, and supported by value-based payment methods. The desired outcome for Goal 1 over the course of the Model Test is for 165 primary care clinics to transform toward the PCMH model. During AY3, Idaho will advance Goal 1 by supporting and monitoring SHIP Cohort One and Two clinic transformation to the PCMH model and recruiting and selecting new clinics to participate in SHIP in AY4 (SHIP Cohort Three).

In AY3, Idaho will…

- Continue to support clinics in SHIP Cohort One.
- Enroll 55 new primary care clinics into SHIP Cohort Two.
- Distribute financial reimbursments to SHIP Cohort Two clinics and monitor fraud/abuse protections.
- Provide technical assistance to SHIP Cohort Two clinics.
- Recruit clinics for SHIP Cohort Three (starting in AY4).

Technical Assistance and Support for Cohort One SHIP Clinics

To support their continued transformation toward the PCMH model in AY3, primary care clinics in SHIP Cohort One requiring additional maintenance and resources will receive continued technical assistance from HMA and PHD SHIP staff. Prior to the end of the their first year of participation in the cohort, HMA will work with PHD SHIP staff and clinic staff to prepare a road map for each clinic's continued transformation based on an updated PCMH assessment. The road map will include any plans for continued technical assistance that the clinic may need. In AY3, HMA will be available to PHD SHIP staff and Cohort One clinics for support as needed.

An important area of technical assistance and support in AY3 will be helping clinics use the data analytics reports that will be a product of Goal 2 and 5 activities. As part of Goal 1, Idaho will explore with healthcare professionals and other stakeholders ways to share this information in order to empower patient choice and spread the highest quality healthcare as the standard of care. This will be an area of focus with both Cohort One and Cohort Two clinics, described in the following section.

Technical Assistance and Support for Cohort Two SHIP Clinics

As established by the milestones for Goal 1, a new group of 55 clinics will participate in SHIP Cohort Two, for a total of 110 primary care clinics participating in Idaho's SHIP in AY3. In AY2, IDHW received a total of 86 interest surveys for SHIP Cohort Two. IDHW received 81 final applicants to the cohort. The 55 clinics for Cohort Two will be chosen using the following selection criteria:

1. Physician champion identification and engagement
2. Clinic type and specialty
3. Geographic coverage statewide
4. Electronic Health Record (EHR) connectivity
5. PCMH familiarity
6. Rural, urban or frontier designation

Public announcement and presentation of the selection of Cohort Two clinics to the IHC will occur at their December 14, 2016 meeting.

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In AY3, SHIP Cohort Two clinics will receive technical assistance from HMA and the PHD SHIP staff. This may also include engaging the RCs in technical assistance activities to increase their awareness of effective mechanisms to support clinics at the local level. AY2 allowed HMA to support the training of PHD SHIP staff and has created the needed capacity among PHD SHIP staff to provide technical assistance for Cohort Two. The table below describes the technical assistance to be provided in AY3 and roles and responsibilities of each party, including that of the primary care clinics. The IDHW SHIP team will work with Briljent/HMA, the PHDs, and the clinics on the tasks below to ensure SHIP cohort clinics are receiving adequate and effective technical assistance.

Table 3 – SHIP PCMH Transformation Roles and Responsibilities Matrix

Tasks and responsibilities	HMA Coach	PHD SHIP Quality Improvement (QI) Specialist	PHD SHIP Manager	Clinic
Coaching Calls	Leads call; Coordinates with QI staff and clinic to identify agenda topics; coordinates scheduling of coaching call; mentors and provides increasing support for PHD QI Specialist to be able to lead the calls.	Required attendance/assists HMA; Gathers agenda topics/recommendations for coaching call topics.	Optional attendance; fills in if PHD QI Specialist has a conflict.	Required attendance; gathers agenda topics/recommendations for coaching call topics, and is prepared to provide an update on activities each month.
PCMH Assessment	Reviews completed assessment and uses it as a guide for monthly coaching call focus areas for transformation.	Assists clinic in completion of assessment.	Reviews completed assessment; may assist PHD QI Specialist.	Completes PCMH assessment and uses it as a tool to identify gaps to focus on for transformation efforts.
Learning Collaborative	Provides training to clinics and PHD staff and an opportunity for face-to-face interaction.	Required attendance and an opportunity for networking with PMCH coaches and clinics; mentored and encouraged to present in Years 2 and 3.	Required attendance; Can present on activities occurring in their regions.	Required attendance – at a minimum by a clinical and administrative staff person – and opportunity for learning and sharing and networking with other clinic teams.

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Tasks and responsibilities	HMA Coach	PHD SHIP Quality Improvement (QI) Specialist	PHD SHIP Manager	Clinic
Transformation Plan	Provides a process and tools to assist each clinic to develop a customized plan, help each clinic implement their plan; is a venue for documentation of plans and progress.	Assists clinic in developing plan, documenting progress and updates as needed within the PCMH portal; facilitates self-assessment of Transformation Plan.	Reviews plan within the PCMH portal as needed.	Creates and maintains plan within PCMH portal; documents goals and progress for each standard they are focusing on.
PCMH Portal	Enters notes from coaching calls; reviews information entered by PHD QI Specialist and clinic to inform coaching call discussions.	Able to effectively navigate portal; supports clinic staff as needed in using the portal; ensures the clinic staff are accurately tracking progress within the portal.	Reviews portal as needed; Can add updates on regional issues or programs that impact this work.	Updates/modifies Transformation Plan as needed; provides notes regarding goal achievement.
Onsite Support	Conducts onsite visit (or as agreed upon by SHIP) to provide more concentrated focus on a particular identified areas of need for transformation to get the clinic further toward recognition-ready.	Visits clinics monthly, or as scheduled to meet clinic's needs, and help identify solutions, gaps and opportunities towards successful adaptation.		Coordinates a regular onsite meeting schedule with PHD staff.

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Tasks and responsibilities	HMA Coach	PHD SHIP Quality Improvement (QI) Specialist	PHD SHIP Manager	Clinic
Identify and Provide Resources as Appropriate	Actively identifies materials and resources related to clinic transformation goals (PCMH concepts, best practices, toolkits, practical applications, sharing experience and/or national efforts and successes).	Actively identifies materials and resources in collaboration with HMA coach; keeps up to date on local, regional and statewide resources related to best practices, local solutions and statewide activities; shares resources with other state QI Specialists.	Communicates with other SHIP managers to connect to regional and statewide peers and resources.	Provides HMA Coaches and PHD staff with pertinent information/resources to assist in transformation efforts that could be shared with other clinics.
Technical Assistance	Provides telephonic, and virtual technical assistance; provider and staff training, team coaching.	Provides onsite, telephonic, virtual technical assistance; provider and staff training, team coaching; coordinates technical assistance needs between clinic and HMA Coach; communicates additional technical assistance needs to SHIP Manager.	Assists with coordinating assistance needs between clinic and HMA Coach.	Utilizes HMA Coach and PHD staff to assist in implementing PCMH components.
National Accreditation Application Support	Provides ongoing PCMH national accreditation application support as identified by the clinic in their designated cohort year.	Provides ongoing PCMH national accreditation application support as identified by the clinic in their designated cohort year; assists when able in post-cohort years.		Utilizes HMA Coach and PHD staff to achieve PCMH goals; completes application.
Sustainability	Provides resources and expertise on sustaining PCMH efforts.	Assists clinics in sustainability planning of PCMH efforts.		Develops a sustainability plan.

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Goal 1 PCMH Reimbursement Payments

Idaho's model includes reimbursement payments to assist primary care clinics in the demanding and often costly process of transforming to a PCMH. The cost of transformation has been estimated to cost upwards of $120,000 with an ongoing operational cost of $30-60,000 annually thereafter[9]. The reimbursement payments have been designed to offset the significant resources required to implement PCMH transformation, as well as a national PCMH accreditation payment designed to offset application fees and other clinic expenditures. In AY3, these reimbursements will be distributed to qualifying Cohort Two clinics.

The one-time clinic transformation reimbursable costs allowed shall include supporting a clinic's initial transformation costs, such as acquisition of additional staff (i.e. care managers, CHWs), technology, patient education materials, other office resources and costs associated with participating in learning collaboratives. Each practice is at a different place on the transformation continuum therefore the reimbursement amounts will vary based on the individual practices circumstance. Every practice with design a transformation plan and proposed reimbursement budget. The transformation plan benchmarks serve as an important fraud and abuse prevention mechanism to ensure that only clinics that are engaged with the Model Test can retain the reimbursement. To retain their transformation reimbursement, clinics must participate in the learning collaborative, attend at least 75% of offered webinars, and attend 100% of coaching sessions with their HMA coach. A total of $550,000 has been allocated for this activity in SIM funds, the total cost Cohort Two clinics will incur (projected) is $6,600,000.

Clinics will also be eligible to receive reimbursement payment to offset the costs associated with achieving national PCMH recognition requirements. In AY2, Idaho changed this payment from an amount up to or equal to National Committee for Quality Assurance (NCQA) 2014 accreditation cost to $5,000, which represents the cost of NCQA application or reapplication costs, site visit fees and other clinic incurred expenses. IDHW also extended this payment to clinics with an existing accreditation that submit evidence of their accreditation to IDHW. IDHW has clarified that clinics that achieve national PCMH recognition after the end of their first year participating in SHIP, but within the Model Test period, can receive the PCMH recognition or accreditation payment. This change reflects Idaho's desire to encourage clinic transformation toward national recognition while also offering clinics flexibility in terms of the timeline for achieving that milestone. A total of $275,000 of SIM funding has been allocated for this activity.

Cohort clinics are also eligible to participate in the Virtual PCMH component of the project as well. This includes establishing a Telehealth, CHEMS, or CHW program to address the workforce shortage and augment healthcare system delivery. Participating clinics will be eligible to receive reimbursement which offsets incurred expenses to develop and implement the Virtual PCMH component(s) of the Model Test. Additional information on the Virtual PCMH program can be found in Goal 4.

Due to lack of capacity the State has procured a practice transformation vendor to provide tailored practice transformation support to each SIM practice- the Vendor on behalf of the State will issue SIM funds to each practice upon achievement of milestones. In AY3, the PCMH reimbursement

[9] http://healthitanalytics.com/news/patient-centered-medical-home-upkeep-costs-8000-per-month

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subcontractor, Myers and Stauffer, will validate and track these payments through the Idaho Payment Accounting System (IPAS); Briljent then issues the payment to the clinic.

SHIP Cohort Three Recruitment

In AY3, the IDHW SHIP team will develop a plan for recruiting SHIP Cohort Three. Like this year, the development of next year's recruitment plan will include input from stakeholders including the IHC, the IMHC, and Medicaid Healthy Connections[10] staff. The AY3 recruitment plan is expected to target three groups: 1) clinics in geographic areas under-represented in SHIP Cohorts One and Two, and 2) specialty clinics and behavioral health providers that also offer primary care services. Through their participation in SHIP, this latter group of clinics will receive assistance from PHD SHIP staff and the PCMH transformation contractor in establishing more advanced PCMH capabilities such as quality assurance policies or other activities identified by the clinic. In addition, the experience of this group of clinics can be utilized to mentor other clinics in the cohort that may not be as experienced in transformation.

The communications materials described in Section B.2 will be a critical component of Idaho's plan to educate and recruit clinics to participate in SHIP. They communicate the benefits of SHIP for clinics and patients as well as the resources and supports available to clinics as they transition to the PCMH model of care. The materials also highlight the fact that Idaho is testing a model that has been chosen based on experience with the PCMHs through the IMHC. These communication materials are considered to have contributed to the large response received to the interest survey for SHIP Cohort Two participation.

In AY3, Idaho will use a variety of recruitment channels to carry these messages to potential SHIP clinics, as was done in AY2. The overall recruitment strategy involves using as many appropriate channels as possible to disseminate a consistent message about the benefits of participating in Idaho's health system transformation. New recruitment activities will be explored to better leverage existing communications platforms in the state, and to ensure achievement of recruitment targets for SHIP Cohort Two.

The IDHW SHIP team will continue to play a primary role in recruitment. The PCMH Implementation Project Manager will send email notifications and other communications and respond to questions from clinics about the model, its benefits, and its requirements. SHIP administrative staff will provide important support for this "customer service" function. The PCMH Implementation Project Manager will participate in healthcare events throughout the state and distribute information about the model. Information will be distributed through a variety of formats, including webinars designed for interested clinics that describe the benefits and resources for clinics participating in SHIP, what a clinic will receive in terms of training and technical assistance from the PCMH transformation contractor, and an outline of expectations for clinics in their first year of participation in SHIP.

PHD SHIP staff throughout Idaho will also play an important role in recruiting during AY3. PHD SHIP Managers and PHD SHIP QI Specialists will assist with local clinic recruitment through direct interactions with clinics based on their existing relationships in their communities.

[10] The Idaho Medicaid Healthy Connections program provides support to practices to expand the PCMH model of care.

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Lastly, Medicaid's Healthy Connections staff is another important recruitment channel. Representatives from the Healthy Connections program interact with clinics on a daily basis and have contacts beyond those available through the IDHW SHIP team and PHD SHIP staff. These representatives will distribute recruitment information through email blasts and discuss SHIP opportunities during their meetings with clinics.

In AY3, Idaho will continue to evaluate its recruitment strategies and, based on lessons learned, adapt these strategies so that primary care clinics are aware of and understand SHIP and are encouraged to participate in a SHIP cohort.

SHIP Cohort Three Clinic Selection and Enrollment Process

While Idaho expects the selection process for the SHIP Cohort Three clinics to follow the current selection process (described below), the actual process may be modified based on provider and stakeholder feedback once the Cohort Two selection process is completed.

Interest Survey

In AY3, Idaho plans to issue an interest survey in July 2017. The name and format of the interest survey was changed in AY2 in response to stakeholder feedback. Clinics reported that the interest application was burdensome and that the term "application" for this document led clinics to believe this was the only application for participation in the SHIP cohort. In response to this feedback, in AY2 the name of the document was changed from "interest application" to "interest survey" to reduce confusion with the final PCMH application. Idaho has also streamlined the number of questions in the interest survey. The interest survey is now a simplified and efficient tool for clinics to express their interest in SHIP and provide contact information for receipt of the final PCMH application. The IHC approved the new interest survey at their July 2016 meeting.

In AY3, submitting an interest survey will not be a mandatory requirement for the selection process, but will allow the IHC and IDHW to gauge the interest of clinics in participating in the Model and identify if there are areas of the state where focused recruitment may be needed. The interest survey will be distributed in multiple formats to ensure broad, statewide distribution. This includes posting the interest survey on the SHIP website; emailing the survey to all clinics in IDHW's listserv; mailing hard copies to all clinics on lists generated by the Idaho Medical Association, Idaho Primary Care Association, and Idaho Academy of Family Physicians; and encouraging clinics to share the survey with other clinics and healthcare professionals. Clinics will have until September 30, 2017 to submit their survey.

Final SHIP PCMH Application

The final PCMH application for participation in a SHIP cohort was also modified in AY2 based on feedback from clinics and input from the IMHC and HMA as subject matter experts in the PCMH model of care. The final PCMH application for SHIP Cohort Two, approved by the IHC on September 14, 2016, may be modified again in AY3 based on stakeholder feedback. One important guiding principle for any future revisions will be to support administrative simplification for applicants. Regardless of potential adjustments that may be made to the final PCMH application during AY3, it is expected that core sections will be maintained to provide information needed to select clinics according to the six selection criteria:

- Physician champion identification and engagement

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- Clinic type and specialty
- Geographic coverage statewide
- EHR connectivity
- PCMH familiarity
- Rural, urban or frontier designation

The application used to select SHIP Cohort Two has seven sections. Four of the sections gather information related to the selection process. Two of the sections request information to aid the IHC, PHD SHIP staff, the PCMH transformation contractor, and the IDHW SHIP team in identifying future technical assistance and resources needed for participating clinics. The table below identifies each section of the application and its purpose.

Table 4 – Final PCMH Application for SHIP Cohort Two

Application Section		Purpose
1.	Clinic Profile	Obtains information relevant to selection criteria of 1) Geographic location in the state, and 2) Rural vs. urban location.
2.	Transformation Plan, History, and Experience	Obtains information relevant to selection criteria of 1) physician/ provider champion identification and engagement, and 2) previous PCMH experience.
3.	Health Information Technology Capabilities	Obtains information relevant to selection criteria of EHR and connectivity: a. should have an established EMR or process for population health management. b. should intend to interface with the Idaho Health Data Exchange (IHDE).
4.	Primary Care/Behavioral Health Integration	Obtains information to identify technical assistance needs. Idaho is a 100% designated shortage area for mental health professional services. Part of SHIP includes goals and metrics related to increasing patient wellness through behavioral health integration within PCMH clinics. This section obtains information on the level of integration currently occurring within the clinic to identify technical assistance needs.
5.	Quality Improvement Activities	Obtains information to identify technical assistance needs. Quality improvement is a hallmark of high-performing PCMHs. Learning more about current quality improvement practices will assist Idaho in providing technical assistance.
6.	Clinic Vision and Intention	Obtains information relevant to clinic's criteria for physician/provider champion identification and engagement.
7.	Completion and Submission	Attestation to completeness and accuracy of the information provided.

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The IHC approved the final SHIP PCMH application for use in selection of AY3 SHIP Cohort Two at their September 2016 meeting.

In AY3, IDHW will present the final SHIP PCMH application to the IHC no later than September 2017, and post the application to the SHIP website in early October 2017. An email notification of the availability of the application on the website will be sent to all clinics that also received notification of the interest survey. Applicants will have 30 days to complete the final SHIP PCMH application.

Clinic Enrollment

After the selection of the Cohort Three clinics is complete, IDHW will notify the clinics and begin the enrollment process. Each clinic will sign an agreement with Briljent to facilitate the flow of reimbursement funding to the clinic once appropriate evidence of expense has been produced. The agreement also details the expectations of the clinic in terms of its participation in trainings and technical assistance activities.

Clinics will also sign a memorandum of understanding (MOU) with IDHW that details the expectations for the clinic in terms of connection to the HIE, interaction with IDHW's data analytics vendor, cooperation with the state evaluation team, and the technical assistance participation benchmarks also included in the clinic's agreement with Briljent. The MOU also includes the supports that IDHW will provide to the clinic.

Other AY3 Activities to Support PCMH Transformation in Idaho

As described above, SHIP-led activities in AY3 will provide important financial and technical support to clinics as they move toward the PCMH model. Idaho's collective efforts to achieve this goal, however, are broader than activities directly led by SHIP. Additional efforts include the important contributions of other state and federal initiatives as well as efforts to address healthcare workforce capacity gaps, which must be remediated in order to fully implement the PCMH model of care in Idaho. Wherever possible, the IHC and IDHW will continue to align SHIP activities with these other initiatives in AY3.

Alignment with other State and Federal Initiatives

An important guiding principle for Idaho's implementation of SHIP is that true transformation must involve alignment among initiatives at the clinic level. To this end, Idaho endeavors to make sure that alignment translates into true coordination at the clinic level.

The presence of multiple initiatives within the same clinic can present a burden on providers as they attempt to meet the requirements of each initiative individually. The intention of SHIP is to build upon and coordinate with other initiatives, not add yet more unique requirements that do not fit within the clinic's broader strategic direction. For example, Idaho is evaluating how to align its metrics with the Quality Payment Program (QPP) to support both progress toward the goals of the QPP and minimize the burden of differing requirements for those providers participating in both SHIP and QPP.

In 2016, Idaho created an inventory of statewide quality improvement initiatives that are present in each of the 55 SHIP Cohort One clinics. The inventory includes initiatives such as Centers for Medicare & Medicaid Services' (CMS') Transforming Clinical Practice Initiative, of which two Cohort One clinics are participants, and Oregon's Healthy Hearts Northwest initiative, which helps clinics implement quality

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improvement processes to improve their patients' cardiovascular health (more information can be found at http://healthyheartsnw.org/).

The primary purpose of the inventory is to help PHD staff and representatives of the other initiatives included in the inventory better coordinate outreach efforts to the clinics. For example, some staff have scheduled calls together to increase collaboration and reduce burden on clinic staff. The tool encourages collaboration on special projects between the clinic and multiple initiatives. Importantly, the inventory also highlights where a clinic is not participating in a particular initiative, which could prompt recruitment efforts.

Moving forward, IDHW plans to make this inventory a public-facing document for anyone to access. In AY3, Idaho will continue to pursue opportunities to increase alignment among initiatives at the clinic level; as the initiatives are identified IDHW SHIP staff will establish ongoing meetings with partners to ensure each programs goals, methods, funding and opportunities to align are fully realized.

Additionally, the IDHW SHIP team will continue to partner in AY3 with Medicaid's Healthy Connections program, which provides support and incentives (including a tiered payment structure) for clinics' continued transformation toward the PCMH model of care. This includes Medicaid Healthy Connection's staff participating in learning activities, site visits and coordination of HITECH dollars to fund clinic connections to IHDE. In AY3, Healthy Connections staff will also begin working directly with Cohort One clinics to continue their journey towards national accreditation and progress toward Medicaid Tier Four payment.

Workforce Capacity

For a number of years, Idaho has been making a concerted effort to increase the number of healthcare professionals in the state, particularly to increase access to services for those in medically under-served areas. Efforts in AY3 to increase workforce capacity, particularly in primary care, will contribute to Goal 1 by providing Idaho with additional opportunities to expand the PCMH model in the state.

The Bureau of Rural Health is seeking to amend the Idaho J1 Waiver[11] program and statute in an effort to increase annual applications to the program. At present, Idaho has 30 slots available per year, of which only one–two slots are utilized. The J1 Waiver program allows foreign medical professionals the ability to work in the United States under a special visa and is designed to target underserved communities. The proposed policy change would expand the definition of physician to include medical specialties and may also permit them to work in non-shortage areas if space allows.

Further, Medicaid has attempted to enhance service delivery and address the workforce shortage in part by amending Idaho Administrative Procedure Act 16.03.09 (on February 1, 2016)[12] to allow primary care providers to deliver billable services via telehealth. Additionally, the Telehealth Council produced a matrix of payers' telehealth benefits[13] that provides a high level snapshot of each payer's telehealth

[11] http://healthandwelfare.idaho.gov/health/ruralhealthandprimarycare/j1visawaivernationalinterestwaiver/tabid/413/default.aspx

[12] http://www.healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/TelehealthPolicy.pdf

[13] http://telehealthcouncil.idaho.gov/Portals/91/Documents/Reimbursement%20Matrix.pdf

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benefit. Individual contracts and provider agreements between the payer and the clinic/health organization ultimately determine the benefits and reimbursement rates, but at a macro level the majority of payers in Idaho are engaged with telehealth.

SHIP seeks to diversify and enhance the workforce through the development of CHWs as a component of the Virtual PCMH (Goal 4). Adding additional healthcare resources to the teams in PCMH practices allows for licensed health professionals to work to the top of their licensure and achieve efficiency with delivery of care. The aim is similar with CHEMS (also in Goal 4): the addition of CHEMS will allow existing community resources to diversify their scope of practice. These enhancements create some relief for the workforce strain and shortage experienced in Idaho. Additional workforce capacity information can be found in Goal 4.

In addition to these direct SHIP activities, the Idaho Health Professions and Education Council (IHPEC) and IDHW's Bureau of Rural Health are two primary groups working in Idaho to analyze workforce needs and develop solutions to expand workforce capacity. Key recommendations from IHPEC include expanding medical residency positions, exploring the feasibility of creating an Idaho Area Health Education Center (AHEC) to increase AHEC funding, and revising Idaho higher education articulation agreements to increase access to Master and Doctoral nursing degrees and, by doing so, to ensure that schools of nursing are adequately staffed to educate nurses. The efforts of IHPEC and the Bureau of Rural Health are showing positive results. Idaho has seen steady increases in the number of active patient care PCPs in the state. From 2010 to 2012 there was an increase from 987 to 1,048 active patient care PCPs; from 2012 to 2014, there was another increase to 1,179 active patient care PCPs.[14]

Unfortunately, despite some increases, the state continues to be challenged by shortages across professions, particularly behavioral health specialists. The table below contains data from the Idaho Board of Alcohol/Drug Certification that illustrates the changes that have occurred between September 2015 and August 2016. The continuing challenges with behavioral health workforce shortages underscore the importance of advancing behavioral health integration within the PCMH model.

Table 5 – Behavioral Health Specialist Workforce Capacity

Professional Credential	September 2015	August 2016	Change
Substance Abuse Counselors	451	424	-6.0%
Social Workers	3,787	3,848	+1.5%
Psychologists	424	442	+4.2%
Total	4,662	4,714	+1.1%

[14] http://members.aamc.org/eweb/upload/2015StateDataBook%20%28revised%29.pdf

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B.4. Goals 2 and 5: The HIT Components of Idaho's SHIP

This section describes Idaho's plans for the HIT components of Idaho's model, which fall primarily under Goals 2 and 5. Goal 2 seeks to improve care coordination through the use of EHRs and health data connections among SHIP cohort clinics and across the Medical-Health Neighborhood. Goal 5 is to build a statewide data analytics system that tracks progress on selected quality measures at the individual patient level, clinic level, regional level, and statewide.

Telehealth is also a critical component of Idaho's HIT plan. In Idaho's model, telehealth is contemplated under Goal 4, so although telehealth is an HIT activity, it is also a core component of Idaho's Virtual PCMH; therefore, information regarding telehealth can be found in Section B.6 of this Operational Plan.

This section provides updated information in the five HIT domains required by Center for Medicare & Medicaid Innovation (CMMI): rationale, governance, policy, infrastructure, and technical assistance. Where HIT components are covered elsewhere in this document (e.g., the Master Timeline, the sustainability plan, or telehealth activities in Goal 4), a cross-reference is included to direct the reader to the relevant section.

Note to the reader: Appendix D crosswalks CMMI's HIT component guidance to the location where the information can be found in this Operational Plan

In AY3, Idaho will…

- Complete connections, evaluate and enhance Cohort One connections to IHDE
- Connect 55 Cohort Two clinics to IHDE.
- Training clinics on how to access and leverage the state HIE technology solution.
- Connect additional hospitals to IHDE.
- Continue to align SHIP HIT activities with the statewide HIT plan.
- Operationalize data reporting on AY3 clinical quality measures.
- Continue to build the data analytics and reporting infrastructure.
- Define baselines for the initial four clinical quality measures.
- Provide technical assistance to support 110 SHIP clinics reporting data on four clinical quality measures and 55 clinics reporting on an additional six measures.
- Provide access to clinical quality measure reports to RCs and other stakeholders.

Overview of Idaho's HIT Activities: Goals 2 and 5

The HIT systems that will be leveraged and created under Goal 2 are an important enabling component of Idaho's vision for delivery system reform. The desired outcome for Goal 2 is that all 165 primary care clinics selected for a SHIP cohort will have an EHR system and an active connection to the HIE, and will use that connection to share and receive patient information. Goal 2 also seeks to support the increase of hospital connections and use of the HIE to share patient data. In AY3, Idaho will continue to provide resources and technical assistance to support attainment of this goal.

Goal 5 builds on the increased clinic HIT capacity and data exchange pathways that are the outcomes of Goal 2 to develop a statewide data analytics system that tracks progress on selected quality measures at the individual patient level, clinic level, regional level, and statewide, supplying information needed to integrate the principles of population health, including e-measurement, at these levels. In AY2, vital work occurred to operationalize the design for Goal 5 and establish critical infrastructure. AY3 activities

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under Goal 5 will continue to build infrastructure, particularly in the areas of data reporting and analytics, which are crucial to driving and evaluating Idaho's health system transformation.

Because health IT is such an important enabling component of Idaho's model, the state has developed specific strategies around health IT governance, financing, and business operations in order to support these activities. The following section describes Idaho's plans in AY3 to implement these strategies to continue progress toward achieving Goals 2 and 5.

HIT Governance and Policy

Alignment with Idaho's Statewide HIT Plan

The State of Idaho began the process of updating its statewide HIT plan in AY2. The aim of this effort is to consolidate several different iterations created by various programs over the years. The statewide HIT plan will outline Idaho's five-year plan to construct a statewide HIT platform for the State. The first draft of the plan will be a starting point to solicit input from stakeholders. The document will be edited as necessary based on feedback and a final statewide HIT plan will be produced. IDHW anticipates the final statewide HIT plan will be published in January 2017. SHIP has contracted with Invoke Health, LLC, a cadre of HIT specialists, to draft the updated statewide HIT plan, gather and incorporate stakeholder feedback, and deliver the final product in January 2017. In this effort, Invoke Health is collaborating with key stakeholders throughout the state, including SHIP, Medicaid, IHDE, hospital systems, the HIT Workgroup, and others. Through this collaboration, IDHW will ensure that its SHIP HIT initiatives are accurately represented in the state's overall statewide HIT plan and that they align with Idaho's statewide HIT targets.

The final statewide HIT plan will be a comprehensive, technical document describing all components of building a HIT platform in Idaho, such as:

- The type of data to be collected, including the following data domains: clinical care (hospital and ambulatory), behavioral health, social determinants of health, and commercial and government payers
- Data collection methods
- Data aggregation capabilities to support the domains mentioned above
- Data and system governance
- Enterprise Master Persons Index (EMPI) and identity management
- Data quality standards and associated mitigating strategies
- Data reporting
- Data security

Statewide HIT Governance

The development of a statewide data governance structure will be an important component of this work. Moving forward, Idaho is creating a statewide leadership group responsible for guiding HIT policy for the state. This activity is pending the review, edit, and adoption of the updated statewide HIT plan (described above). IDHW anticipates that the statewide leadership group will include an independent neutral convener and will be broadly representative of the key HIT stakeholders in the state, such as: health systems, mid-size private practices, private health insurers, Medicaid, state public health agencies, federally qualified health centers (FQHCs), community mental health centers, the legislature,

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and significant social service agencies. Through the statewide HIT plan development process, stakeholders will determine how governance will be organized, such as through a board of directors and committees responsible for overseeing elements of the HIT platform (e.g., privacy and security, clinical quality, finance, data, and analytics).

SHIP Data Governance Group

The IHC and IDHW will continue to be responsible for guiding and overseeing implementation of Goals 2 and 5 in AY3. Currently, the IHC's HIT Workgroup and the Clinical Quality Measures (CQM) Workgroup share responsibility over data governance. In AY3, Idaho will likely combine these two work groups to form a workgroup focused on both the data connection and the data integrity components of HIT activities. IDHW has requested technical assistance from the Office of the National Coordinator for Health Information Technology (ONC) in creating this data governance group; specific activities in AY3 will follow guidance received from ONC.

Based on previous technical assistance activities and discussions, the new data governance group will be broadly representative of multiple stakeholders and will likely include current members of the HIT and CQM Workgroups as well as payers, who are important stakeholders in HIT activities. The group will be responsible for advising on topics related to CQM selection/refinement, data governance standards that impact CQM calculations (such as how to treat an EHR's data that leverages local codes instead of standardized codes such as ICD-10 or SNOMED codes), data quality, and data privacy and security policies.

No regulatory or legislative changes are contemplated to support or impact Goal 2 or Goal 5 in AY3.

HIT Risk Identification and Mitigation

Risk identification and mitigation for Goals 2 and 5 in AY3 will follow the process described in Section D.3 of this Operational Plan. Risks are captured in a risk log and, depending on the probability and impact of each risk, mitigation strategies and contingency plans are developed and activated. IDHW and Mercer project managers discuss and frequently update the risk log. IDHW submits the risk log and discusses issues in the log with CMMI on a quarterly basis, and more frequently as requested. In AY3, IDHW will continue the established risk management process.

Additional information regarding particular risks associated with Goals 2 and 5, as well as mitigation plans to address these risks can be found in the risk log in Appendix B.

Goal 2

In AY3, Idaho's efforts to optimize new and current HIT at the provider, payer, and state level to implement delivery system reform will continue under Goal 2. Goal 2 activities leverage stakeholders' subject matter expertise and commitment to the model, and infuse resources and support to build the next generation of health data exchange and data-driven care coordination in Idaho.

The figure below illustrates the data flows envisioned with an integrated Medical-Health Neighborhood. Some of the flows illustrate as-is connection types while others are envisioned and have yet to be funded or fully realized.

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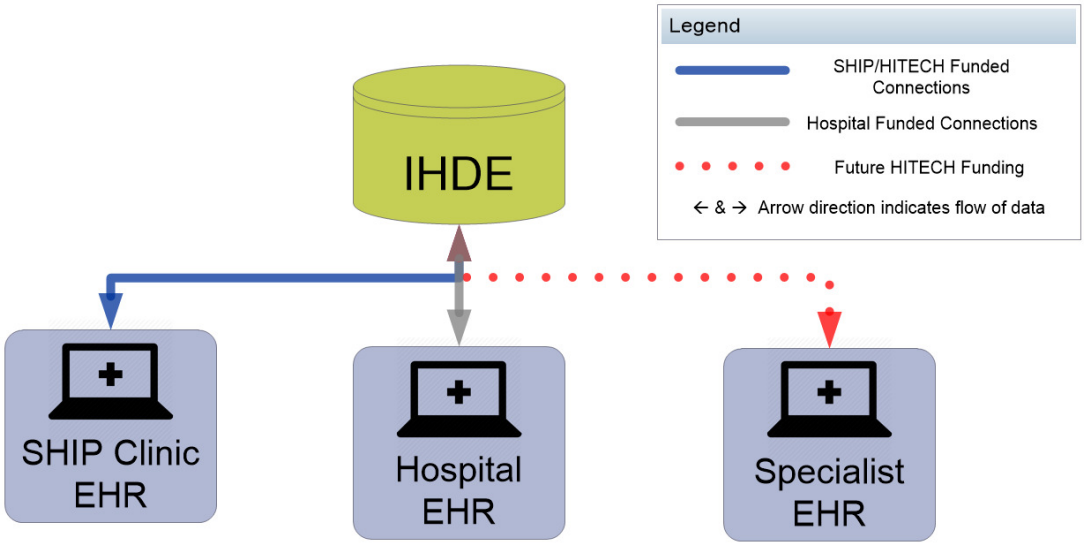
Figure 7 – Data Flow Illustration for Service Delivery by Connection Type



Clinic Data Sharing through IHDE

Activities in AY3 will be aimed at finalizing bi-directional connections between SHIP Cohort One clinics and IHDE, and establishing bi-directional connections between SHIP Cohort Two clinics and IHDE. A bi-directional connection enables clinics to both send and receive patient-level information directly through their electronic health record (EHR).[15] All participants in the IHDE retain access to a standalone portal in which individually issued credentials can be used to access and view patient data supplied by sources (e.g. hospitals, clinic, and specialist). The exact technical specifications of each clinic's bi-directional connection to IHDE will vary based on the capabilities of the clinic's EHR product. However, in general, clinics will use the bi-directional connection to share their patient Continuity of Care Documents (CCDs) as well as clinical transcriptions (progress notes). In turn, clinics will receive from IHDE relevant patient data from other providers, including hospitals, such as lab work, radiology, and transcriptions.

There are two directions in which data will flow between IHDE and the clinic. Client data that travels from the clinic EHR to IHDE is "inbounding" to IHDE. Client data that travels, or is accessed through the view portal, from IHDE to the clinic EHR is "outbounding."[16] At present, Medicaid has included connection to IHDE in their tier system; clinics outbounding data (uni-directional) will qualify for Tier 3 payments while clinics with both inbound and outbound connection (bi-directional) will qualify for Tier 4. Medicaid has additional non-HIE criteria for clinics to address before they move between payment tiers.

[15] The technical definition of "bi-directional connection" for the purposes of SHIP is: Exchange of information including both discrete and textual data using HLN7 interface technologies as well as other data exchange technologies including but not limited to CD formats, XDS exchange, and other emerging technologies.

[16] These terms have been adopted from the IHDE perspective and are Idaho-specific in nature.

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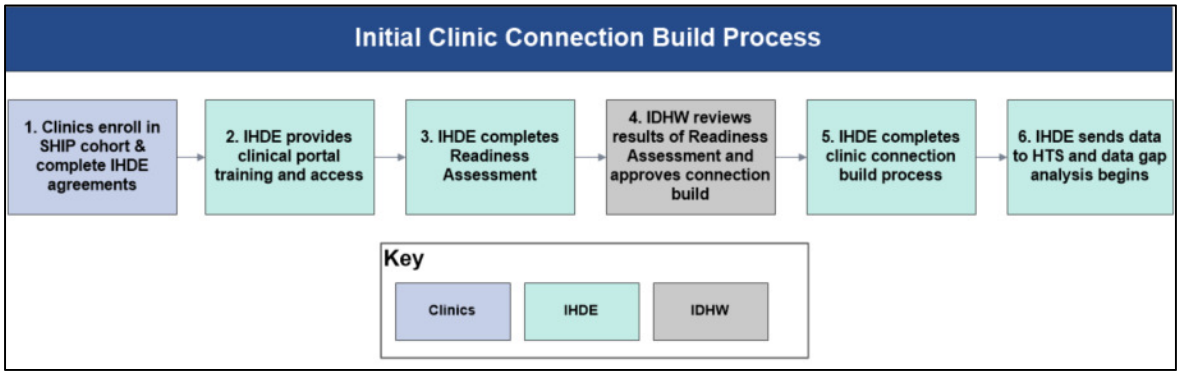
Prior to the start of SHIP several hospital systems had already established relationships and data feeds with IHDE. These feeds were usually ADT (Admit, Discharge and Transfer), RAD (radiology), and LABS (laboratory); and only transmitted data from the hospital system to IHDE (uni-directional). Similarly, many clinics in Idaho were customers of IHDE and are consumers of the data available in the IHDE database; these clinics, some now SHIP Cohort One clinics, are also uni-directional connections. As the fully realized vision of bi-directional connections is implemented, SIM and HITECH funding are being leveraged to enhance these existing connections to make them bi-directional as well as connect additional service delivery providers in Idaho. Funding connections for hospitals is not currently part of the SIM funding proposal; however, many hospital systems in Idaho operate outpatient clinics now participating in Cohort One. The hospital and clinic often share the same EHR and the connection required to onboard the clinic is scale-able to the hospital side at the same cost. In these instances, hospitals receive benefit at no additional cost to the SIM or parent health organization.

In AY3, the process for establishing data sharing through IHDE will be similar to the process established for SHIP Cohort One, illustrated in the figure and description below

Figure 8 – IHDE Connection Flow



- After a clinic's enrollment in SHIP Cohort Two, the clinic signs a series of business associate agreements with IHDE that establish the responsibilities of each party and govern their relationship. Importantly, the agreements include privacy and security safeguard policies to ensure compliance with Health Insurance Portability and Accountability Act (HIPAA) and all other applicable federal and state laws and protect the sharing of personal health information through IHDE.
- After signing the business agreements, IHDE conducts training with the clinic to demonstrate the IHDE clinical portal user interface, to assist the clinic in accessing clinical records through the portal, to review privacy policies and procedures, and to suggest ways for the clinic to incorporate portal access in their workflows. At this point in the process, the first year license fee to access the portal is waived and the clinic is granted "view-only" access to the portal. This step gives the clinic access to the system while the connections are being scoped and built by various vendors.
- IHDE then conducts an HIE-specific readiness assessment with each clinic to evaluate the clinic's capacity for bi-directional connection to IHDE. The readiness assessment collects information on the clinic's EHR product, the EHR one-time connection costs, any current connection the clinic has to IHDE, and what type of data is currently being shared with IHDE. To assess the clinic's data reporting capacity in support of Goal 5. In AY3, the CQM data quality process will leverage successes and

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opportunities that clinics experienced related to national metric reporting as a component of their individualized process.

- IHDE sends the readiness assessment to the IDHW SHIP team; the SHIP team approves the readiness assessment which authorizes IHDE to begin working with the clinic to establish a connection to IHDE. Building the connection occurs over a 12-week sprint.

In AY2, IDHW and IHDE identified barriers to establishing these connections and developed plans to overcome the barriers. Examples of barriers included: challenges associated with the flow of behavioral health data due to privacy issues, the need for a patient attribution mechanism to associate patients with clinics, and delays associated with clinic EHR conversions. In AY3, IDHW and IHDE will continue efforts to address these barriers so that full clinic connections can be established. If new barriers are identified, IDHW and IHDE will work in a similar fashion to implement solutions so that progress toward Goal 2 can continue.

In AY3, connections will be finalized for approximately 33 Cohort One clinics that did not complete the process in AY2. Cohort One clinics may also require enhancements to their connections to support the six additional quality measures they will be reporting on in AY3. Concurrent with the work to finalize and enhance Cohort One clinic connections, IDHW and IHDE will also work in AY3 to establish connections for the 55 clinics selected for SHIP Cohort Two.

Funding for IHDE Connections

During AY3, Idaho plans to continue leveraging Model Test grant funds for SHIP Cohort Two to help reduce any barriers that fees may pose to clinic connection to IHDE. Additionally, the IDHW SHIP team is working with Medicaid to leverage HITECH funding to help cover the connection costs. The following table shows the fees normally associated with a clinic's connection to IHDE, and how these fees will be handled for SHIP Cohort Two clinics during AY3.

Table 6 – Fees for Data Sharing through IHDE

Fee	Description	Funding Source for SHIP Cohort Clinics
One-time IHDE interface connection fee – IHDE and subcontractor cost.	Portion of the one-time connection fee that represents the professional services required to connect the clinic's EHR to IHDE.	Medicaid HITECH funding is proposed to cover 100% of the costs.
One Time EHR interface connection fees – EHR charges to clinic.	Portion of the one-time connection fee that represents costs associated with coding and technical work at the EHR level to establish a connection to IHDE. Costs range from $10,000 to $40,000 depending on the EHR product.	SHIP will fund 100% of this cost. This expense is not eligible for HITECH funds.
IHDE clinical portal license fee.	Annual license for use of the IHDE clinical portal. Each license supports up to four clinic users. Multiple licenses may be required depending on the size of the clinic. On average, Cohort One clinics use two to three licenses, each costing $475.	Medicaid HITECH funding is proposed to cover 100% of the costs in the first connection year. Clinics will pay this fee thereafter.

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Fee	Description	Funding Source for SHIP Cohort Clinics
EHR maintenance fees.	EHR vendor-related maintenance fees (e.g., monthly support) resulting from the connection to the IHDE.	No SHIP funding or waivers are available for this fee. Clinics will pay these fees directly to their EHR vendor.

Part of AY3 grant funding will also be leveraged to support the completion of SHIP Cohort One clinic connections to IHDE. This funding allocation will likely be offset by decreased connection costs for Cohort Two clinics. The reason for the decreased costs is that several Cohort Two clinics will likely be part of larger health systems that achieved system-wide connection via a SHIP Cohort One clinic connection. Medicaid HITECH funding is anticipated to further offset the connection cost for Cohort Two clinics.

In addition to the above financial support through SHIP, Cohort One and Two clinics with a bi-directional connection with IHDE are closer to achieving a higher tier payment through Medicaid. In AY2, Idaho's Medicaid program released a tiered payment structure that provides further incentives for clinics to connect to IHDE. Through this structure, clinics receive a higher per member per month (PMPM) payment for achieving view access to IHDE through the clinical portal. Clinics can achieve an even higher PMPM by establishing a bi-directional connection to IHDE. Moving forward, these payment enhancements through Medicaid will continue to motivate, support, and sustain provider investments in connecting to IHDE.

Hospital Data Sharing Through IHDE

In AY3, IHDE also anticipates increasing hospital connections to IHDE. The process for establishing hospital connections and the nature of hospital connections will be different than clinic connections. While all connected hospitals will send clinical information to IHDE (inbound), some hospitals may choose to not automatically receive clinical data from IHDE (outbound) due to security and IT policies at the organizational level. Providers within these hospital settings will still be able to view clinical data on their patients through the clinical portal.

Within Idaho there are several geographic areas where hospital connections to IHDE are limited, and the availability of patient clinical data has been a barrier for clinics in deciding to connect. Though SHIP has not allocated funding specifically for hospital connections, the presence of patient data from the clinic is anticipated to become an incentive for hospitals to consider joining IHDE. For example, SHIP clinics connected bi-directionally with IHDE will be providing patient data including medications, allergies, lab results, progress notes and other important health data to IHDE. This could be crucial in the event the patient is seen in an emergency room late one evening. The treating physician in the emergency room would have access to much of the patient's health history increasing the effectiveness of their treatment and preventing duplication of diagnostic or treatment services.

In AY3 it is anticipated that at least three new hospitals will be connecting to IHDE bringing the total number of hospitals to 11 representing 2,133 beds statewide.

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Other AY3 Activities to Support Data Sharing and HIT-Enabled Care Coordination

Idaho will also continue working toward expanding IHDE to include claims data from payers in Idaho. IHDE will use findings from an AY2 feasibility study which examined cost and timeline to facilitate the expansion of their business to include this data. This issue will be evaluated by the HIT Workgroup as well as the board of IHDE. At the time of this Operational Plan submission, the feasibility study findings were not complete.

Idaho will also continue investigating the possible expansion of IHDE through connections to regional HIE databases. By the end of AY2, IDHW anticipates receiving the results of a feasibility study from IHDE that evaluates this issue. Based on the results of this feasibility study, in AY3 IDHW and IHDE will determine the appropriate next steps.

HIT-enabled care coordination will strengthen the working relationship of Medical-Health Neighborhood participants with SHIP cohort clinics and across Medical-Health Neighborhood participants. A first step will be to expand electronic information sharing across "traditional" medical practices such as specialty providers, hospitals, and primary care clinics. Eventually, Idaho hopes that the infrastructure currently being built will allow opportunities beyond these traditional providers in order to support communications across the Medical-Health Neighborhood. For example, broader HIT-enabled care coordination in the Medical-Health Neighborhood between local behavioral health providers and correctional health practitioners would help facilitate successful reentry for many individuals transitioning into the community. Likewise, sharing data between tribal and non-tribal Medical Health Neighborhood participants would improve care for many tribal members who receive services both on and off tribal land. The creation of the Medical-Health Neighborhood and the development of the infrastructure to support HIT-enabled care coordination will eventually intersect, and provide expanded opportunities across the broader Medical-Health Neighborhood to understand and address the person's whole needs.

Detailed HIT Functionalities for Goal 2

CMMI's guidance to states on the HIT components of their SHIPs requests detailed information for the specific HIT functionalities that will support delivery system reform. The following table provides this detail for these functionalities in Idaho under Goal 2.

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Table 7 – AY3 HIT Support for Delivery System Reform

Health IT functionality	Information Purpose & Location	Current barriers	Funding	Policy Levers Utilized	Fully Operational Date
Data Extraction: Provider interface between EHR and IHDE; includes HL7 interface, CCD formats, and attribution flat files. Currently operational but does not currently meet statewide SIM needs.	Improve care coordination via electronic health records (EHRs) data flow to HIE allowing both clinical data to be accessed for patient care coordination and data analytics reporting.	• Variety of EHR products with varied connectivity standards • Contract delays • Provider readiness • EHR technical resource allocation	HITECH and SIM	No additional levers have been identified at this time.	Varied based on cohort.
Data Aggregation: IHDE system ability to receive, parse, and organize data into the database in necessary discrete fields. Currently operational and can be used as is to meet statewide SIM needs.	Repository of necessary clean and ready to use data for analytics vendor output. Located within the state HIE system.	• Technical barriers • Contractor delays • Resource availability • Cost for new vendor functionality	SIM	No additional levers have been identified at this time.	July 2017
Data Transformation: IHDE system ability to standardize already organized data. Currently operational but does not currently meet statewide SIM needs.	Process of cleansing, de-duplicating[17], and translating data into ready to use format for analytic vendor output. Located within the state HIE system.	• Dependency on predecessor tasks	SIM	No additional levers have been identified at this time.	July 2018

[17] Reconciling historic or duplicate message contents received via HL7, CCD or other XML format. This is anticipated to require creation of several data algorithms and hierarchies.

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Goal 5

Under Goal 5, Idaho will utilize new and current HIT to support the integration of population health into the state's SHIP activities, including e-performance measurement.

Operationalizing the CQMs for Data Reporting and Analysis

In AY3, Idaho will continue work to operationalize the CQMs for data reporting and analysis. This process began during the Model Design phase, when the state created Idaho's Initial Core Performance Measure Catalog, a set of CQMs addressing Idaho's top population health concerns that were to be targeted for improvement during the Model Test. While this Catalog established the measures for the Model Test, it did not include the level of detail needed to operationalize data reporting on each measure.

In January 2016, the IHC formed a new subcommittee of the HIT Workgroup called the Data Element Mapping Subcommittee, with membership including HIT Workgroup members, CQM Workgroup members, providers, payers, IDHW's data analytics contractor (HTS) and the IHDE. The HIT Workgroup charged this subcommittee with refining the measures in sufficient detail to support data collection and analysis. This work involves mapping the CQMs and ensuring alignment with national measures and best practices. During AY2, IDHW also contracted with KMP to support the efforts of the Data Element Mapping Subcommittee.

In AY2, the subcommittee selected four of the 16 measures that SHIP cohort clinics would begin reporting in AY2 and worked to operationalize the four measures. As part of their review, the subcommittee identified issues that would create barriers to reporting the measures as they were originally contemplated, such as multiple workflow changes at the clinic level and potential EHR technology constraints in generating the data. To address these barriers, the subcommittee recommended modifying the measures to enable timely and accurate reporting. The modifications aligned the measures with nationally accepted measures for other reporting initiatives: CMS, PQRS, and National Quality Framework (NQF) for example. These national measures already have clearly defined data logic (inclusion, exclusion criteria) for the numerator and denominator and already identify the data elements needed to calculate the measure. In addition, aligning the measures with existing national metrics allows SHIP cohort clinics to leverage reporting they may be already doing to meet requirements for other reporting initiatives both current and upcoming (i.e., measures included in the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA)).

The Data Element Mapping Subcommittee then began a similar process to define the numerator, denominator, and data elements for the remaining 12 CQMs. In AY3, the Data Elements Mapping Subcommittee will complete any remaining work to refine and operationalize data reporting on the remaining CQMs. This includes developing supporting documents, making formal recommendations to the HIT Workgroup and addressing challenges identified by contractors implementing the CQMs.

CQM Reporting Schedule

In AY3, Idaho will follow the schedule developed in AY2 for CQMs reporting during the three years of the Model Test. Stakeholders emphasized the need for the schedule to allow phase-in of the remaining reporting requirements. A phased-in approach will allow clinics sufficient time to implement internal

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changes to capture data at the clinic level, while also allowing IHDE and HTS time to build the data analytics infrastructure needed to produce reports on the data.

The schedule also requires SHIP clinics to increase reporting over time. In their first year of participation in a cohort, clinics will be required to report on the first four measures. The reporting requirements will increase by six measures each year of the Model Test. This approach will enable clinics to establish solid baselines for each measure and afford them time to address any gaps that are identified in reporting the measures. Additionally, lessons learned each year will be applied to increase the possibility of AY3 and AY4 cohort clinics reporting on more than the required measures.

In this manner, all clinics will build reporting over time as their experience participating in the Model increases. Table 8 describes this progression.

Table 8 – CQM Reporting Schedule

Number of Required Measures for Reporting			
	By January 31, 2017	**By January 31, 2018**	**By January 31, 2019**
Cohort One	4	10	16
Cohort Two	0	4	10
Cohort Three	0	0	4

Building and Operationalizing the Data Reporting Pathway

In AY2, IDHW worked with the HIT Workgroup, IHDE, and HTS to define and operationalize the reporting pathway for CQMs from cohort clinics to IHDE and ultimately to HTS. As the data analytics contractor, HTS is responsible for providing data hosting, data transfer, analytics design and development, testing, and display of analytics output at the participating clinic level, county level, RC level, and statewide level. Clinic designated staff with appropriate security will be able to drill down to the patient level.

The Figure 9 illustrates the data pathway for reporting of the CQMs.

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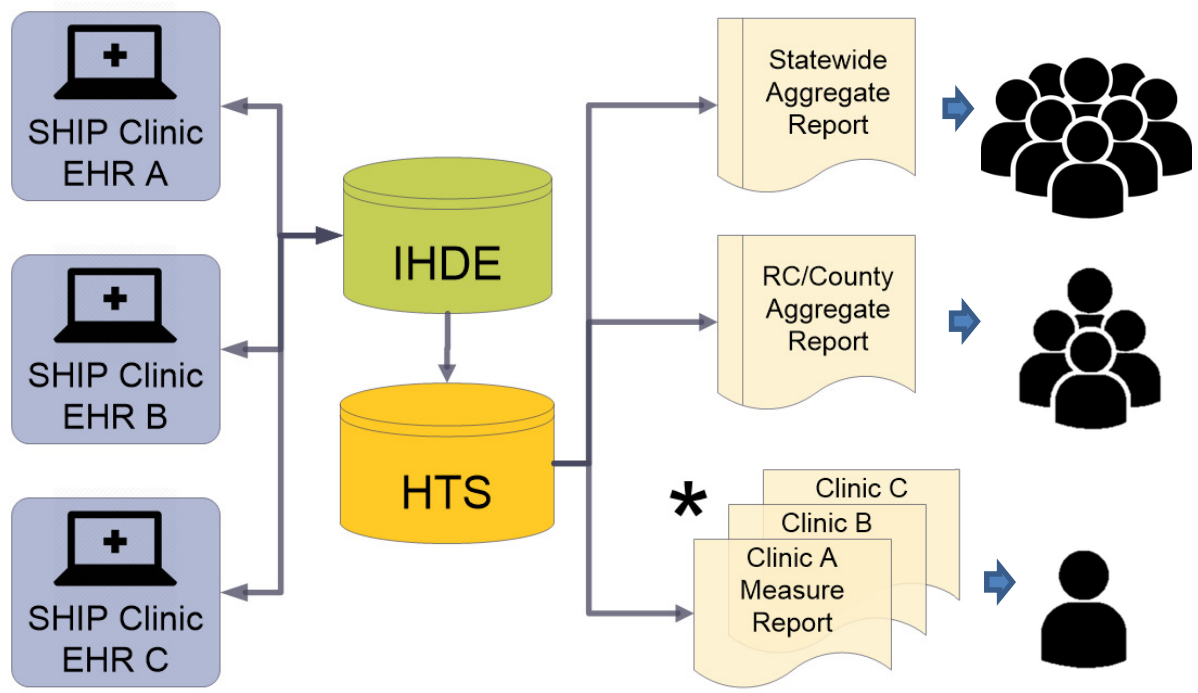
Figure 9 – CQM Data Reporting Pathway



*Clinic Measure Reports allow for client level drill down (with appropriate credentials).

Below is a brief summary of activities in AY2 that laid the foundation for AY3 activities.

- To address any potential privacy and security concerns associated with data sharing, the IHDE's legal counsel and its Privacy and Security Council reviewed relevant policies and procedures, including its patient privacy notice, to ensure that these policies accommodated data sharing with HTS for the SHIP clinical quality reports. IHDE provides the foundational data governance, privacy, and sharing for the State of Idaho.
- Bi-directional connections to IHDE were established for some Cohort One clinics. HTS ran a data gap analysis report for each clinic with a connection to IHDE that identified any CQM data that was missing from the clinic's transmission, either due to a clinician work flow issue, or a clinic connection issue. Based on the results of the data gap analysis, IHDE and the clinic worked to identify solutions to address the gap, which could involve modifications or subsequent connection build. The gap analysis process was repeated until all gaps were addressed and the clinic's data was complete.
- HTS established a connection with IHDE to receive the CQM data.
- The Data Element Mapping Subcommittee developed a solution to ensure a patient's EMPI number would be used for data analytic reporting. Utilizing the patient attribution file supplied by the clinics, IHDE identified the EMPI number of each patient. The EMPI number will be included in the extract to HTS, stored in the HTS database, and will enable HTS to accurately attribute a patient to a clinic.
- The HIT Workgroup established a Use Case Subcommittee of subject matter experts to ensure that the data analytics architecture was designed and built with end users in mind (i.e., clinics, RCs, and the state). A "use case" is a term used in the development of a system, which describes the step-by-

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step process a user goes through in interacting with a system to accomplish a particular goal. The use cases for a system capture all the possible ways the user and system can interact to achieve defined goals. For example, the group developed a use case for a SHIP cohort clinic viewing a report showing the percentage of male patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user. The use case group met initially in July 2016 to identify all use cases. Designated members were then assigned to fully document the use cases and report back to the group for review and approval. The use cases were approved on October 13, 2016 and were presented to the subcommittee.

- HTS used information from the use cases to build and validate a data analytics system architecture that supports the various users' reporting needs while at the same time maintaining the appropriate security levels by user. HTS is expected to complete all necessary technical work to support reporting for the first four CQMs by the end of AY2. This includes developing the logical and physical data model, the extract transform and load processes, file transmission protocol, and configuration of the rules for reports.
- Before launching data reporting (anticipated mid-January 2017) on the first four CQMs, the data reporting pathway was tested with SHIP cohort clinics that provided sample data to IHDE. Based on lessons learned from the first clinics, HTS and IHDE began making adjustments to the process as needed to prepare for reporting by all 55 SHIP Cohort One clinics.

Because data reporting is dependent on successful connections to IHDE, reporting is being implemented one clinic at a time as connections are built and validated, and gap analyses are completed. This process will continue in AY3 to enable more clinics to transmit better data on more measures. The SHIP Cohort One clinics that did not connect by the end of AY2 will complete this process. When the process is complete for the first four measures, Cohort One clinics will begin required reporting on the next six measures. The SHIP Cohort Two clinics will begin required reporting on the first four measures and optional reporting on the second group of six measures.

In AY3, stakeholders will continue to work through any specific challenges that arise tied to operationalizing the data flow. This will include continuing to implement activities to improve data quality. At the clinic level, IHDE and HTS will work with clinics to resolve issues and improve data quality to ensure that metrics represent accurate information. Plans will also be finalized related to aggregate data cleansing and data normalization. While planning has begun related to these latter tasks, in AY3 IDHW will continue to work with the state's HIT governance group and stakeholders to identify the resources needed and available to conduct these tasks and begin aggregate data cleansing and data normalization.

Clinical/performance data across multiple payers has never been available before in Idaho. The availability of this data will be a new tool in understanding and improving regional and state population health. Idaho's vision is for this data to eventually be used at the local level by RCs and PHD staff to objectively understand community-specific and regional population health issues. It will take some time before the RCs are organized well enough and relationships are cemented across the Medical-Health Neighborhood for this data to be used to develop quality improvement activities within specific practices and/or networks and population health initiatives with regions or at the community-level.

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Given that this data has never been available, it is challenging for the RCs at this time to finalize plans and processes for how they will use this data to improve regional health.

It is expected that the use of this data will unfold gradually across the RCs, and RCs will need assistance and support from the PHD staff in understanding what information is available to them and how the data can be effectively used as both a population health tool and provider network clinical quality improvement tool. Working with PHD staff and under the continued guidance of the IHC, all RCs will eventually begin to utilize the powerful information that will be available to them through the HIT foundation of performance data that began in AY2 and will continue to be built in AY3 and beyond.

Establishing Baselines

After data transmission is established per the process described above and issues have been resolved through the data quality analysis process, baselines for each measure will be established for each SHIP cohort clinic. HTS will produce a draft baseline report for each clinic. It is unknown how long it will take to get a 'clean' baseline from clinics, as portions of the data quality cleansing process may require practice workflow changes, EHR entry change or even vendor programming changes. With support from IHDE, the clinic will review the report to evaluate whether the report is consistent with their understanding of their clinic's data. Any issues identified by the clinics will be analyzed and resolved through discussions between IHDE, IDHW, the clinic, their EHR vendor and HTS. After all parties are satisfied that the data is complete, HTS will set the baseline that will be used to measure future progress.

Data Analytics Feedback

HTS will provide data analytics feedback at the clinic level for improving the care of the patient population, at the county and regional level for identification of quality indicators to focus on at the regional level, and at the state level to provide direction in evaluating the overall success of the Model Test. This feedback will be available soon after connections are established. Information at the regional and state level will continue to get more robust as additional clinics begin reporting data.

HTS will also create custom reports on the CQMs based on the use cases developed by the HIT Workgroup's Use Case Subcommittee. Custom reports will be available for clinics, RCs, and the state, and are meant to help make the data more useful for identifying both practice-specific issues and regional and statewide population health issues. Custom reports were defined with provider, PHD, and RC input to provide them with data most relevant for identifying gaps in care and community health needs.

Data analytics feedback that will occur in AY2 will provide Idaho with a mechanism to identify, plan, and implement population health improvement activities at a level never experienced in Idaho. In addition to regional health information, care delivery systems will be able to see how network providers participating in the SHIP cohorts are performing across the clinical measures. The availability of this information is expected to incentivize care delivery systems to encourage all network members, not just those in the SHIP cohorts, to participate in the HIT infrastructure being leveraged and created to support data collection and reporting. Care delivery systems will have the opportunity to use this information in a variety of ways, including the attribution of an individual for purposes of population health to a provider, quality improvement activities, and support of local and statewide population health activities.

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Other AY3 Activities to Support Clinical Quality Measurement

Discussion with payers will continue in AY3 to determine what reports will be most useful to them particularly as it relates to providing data that support alternatives to fee-for-service (FFS) payments. Payers will receive aggregated CQM reports (county and region level) in AY3. These reports are expected to be a useful tool to help payers identify regional and statewide population health activities that will benefit their membership.

General discussions have occurred between the RCs, PHD staff, and the IHC about performance data reports that will be available to them to broaden their understanding of regional health needs. In AY2, the primary focus for the RCs has been the development of their strategic plans and establishing relationships with the Medical-Health Neighborhood. As performance reports become available through activities underway for Goal 5, more discussions will occur with the RCs to help them understand the information available to them. The PHD staff and the IHC will play critical roles in facilitating these discussions and the eventual use of these reports to design targeted quality improvement and population health activities.

Detailed HIT Functionalities for Goal 5

CMMI's guidance to states on the HIT components of their SHIPs requests detailed information for the specific HIT functionalities that will support the information/data needs for integration of population health, including e-measurement. The following table provides this detail for these functionalities in Idaho under Goal 5:

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Table 9 – AY3 HIT Support for Population Health

Health IT Domains of OP Purpose & Location	Health IT functionality[18]	Current barriers	Funding Source	Multi-payer Policy Levers Utilized	Start Date/ Fully Operational Date
CQM data will assist state SHIP team, clinic and hospital providers, RCs, and other stakeholders for purposes of population health reporting and the development of population health initiatives.	**Data extraction:** Rhapsody Integration Engine (Orion)	Limited data availability	SIM/HITECH	N/A	4/8/16 - 12/31/18
	Data Collection: Microsoft SQL Server Database Tools are used to transform and load the data into the data analytics system.	Limited data availability	SIM	N/A	4/8/16 - 12/31/18
	Data Transport: From IHDE to HTS via SFTP using SSL connections.	Limited data availability	SIM	N/A	4/8/16 - 12/31/18
	Data Retention: Amazon Web Servers	Limited data availability	SIM	N/A	4/8/16 - 12/31/18
	Data Analysis: SAP Predictive Analysis	Limited data availability	SIM	N/A	4/8/16 - 12/31/18
	Data Reporting and dissemination: SAP Business Object Enterprise	Limited data availability	SIM	N/A	4/8/16 - 12/31/18

[18] All HIT functionalities listed in this table are currently in implementation stage and can be used upon completion to meet statewide SIM needs.

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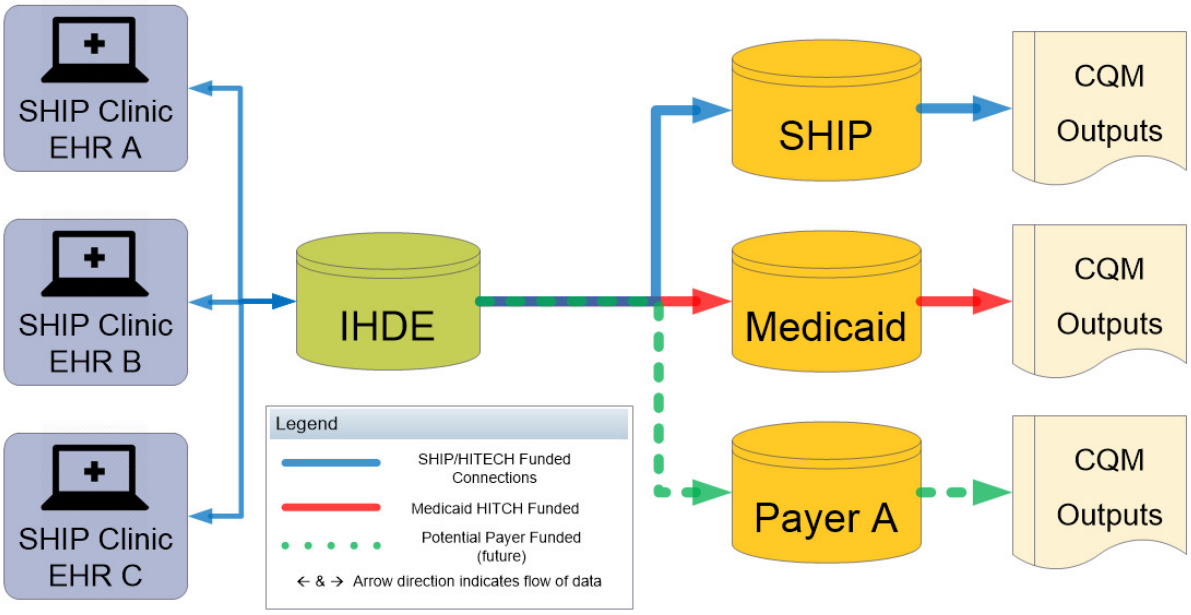
HIT Support for Payment Reform

Idaho's model recognizes the importance of offering flexibility to payers in defining how they will support payment reform. Thus, Idaho is not creating any additional common HIT infrastructure that would create a single data flow for payment reform. Instead, in AY3, each payer will implement their own HIT activities to support their particular payment models and contracting arrangements with providers. SHIP will support these efforts by sharing data analytics reports with payers, as described in more detail below. With this flexibility, Idaho anticipates that public and private payers will continue to be engaged and committed to new models of healthcare delivery and payment models.

Payers will continue to have an important seat at the table in designing and implementing the SHIP HIT activities. Several payers have been participating in the IHC's HIT Workgroup and this participation is anticipated to rise and include all Idaho payers in AY3. SHIP will be forming a SHIP data governance group inclusive of clinicians, payers and HIT professionals to support implementation of the SHIP HIT components.

Figure 10 – Clinical Data Pathways Supporting Payment Reform



As previously noted, payers will be using the information provided through SHIP data analytics on county, regional, and statewide levels. For example, payers currently only have regional and statewide clinical information on their own provider networks. The performance reports that aggregate clinical data across all payers will help payers identify if there are quality improvement activities that should be targeted toward specific providers or provider networks and supported by value-based purchasing to incentivize and reward payment. This data may help providers pinpoint the types of data that is useful to establish alternatives to FFS models and support regional and state-level population health initiatives that benefit their members.

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HIT Technical Assistance

Technical assistance will be an important part of implementing HIT activities in AY3. All HIT vendor contracts include a TA component in which the vendor provides expertise and support to the various customers including: PCMHs, RCs, PHDs, and other identified users of the HIT infrastructure. For example, SHIP Cohort Clinics will receive technical assistance from HTS, the data analytics vendor, related to access, use and leveraging data which will contribute to improved patient outcomes.

Table 11 below outlines the technical assistance activities planned in AY3:

Table 11 – AY3 HIT Technical Assistance

Targeted Provider Type	Health IT Technical Assistance To Be Provided & Funding
SHIP Cohort Clinics	Various topics related accessing the solution, producing reports, and customization tool functionality. Funded through SHIP.
Users of county and regional CQM reports (PHD, RC)	How to access the reports for population health monitoring as well as understanding the data sources. Funded through SHIP.
Users of statewide CQM reports	How to access the reports for population health monitoring as well as understanding the data sources. Funded through SHIP.
Users of CHEMS metrics reports	How to use the reports to measure the success of CHEMS programs. Funded through SHIP.
Virtual PCMH telehealth applicants	How to develop telehealth grant application. Funded through SHIP.

HIT Work Plan and Timeline

Information regarding Idaho's HIT work plan can be found in the Goal 2 and Goal 5 work plans in Section C of this Operational Plan. Information regarding the timeline for HIT activities can be found in the Master Timeline in Section A.4. In addition to specific sections for Goals 2 and 5, the Master Timeline includes a column that describes where HIT activities support other components of SHIP.

HIT Driver Diagram

Idaho's HIT activities are a primary driver of the State's health system transformation and are represented as Primary Driver Two in the master driver diagram in Figure 1 of this Operational Plan. Figure 3 shows the metrics for Primary Driver Two. There are HIT activities that support Primary Driver 1 and 3; narrative details can be found in Goals 1, 3, and 4.

Sustainability Plan

Information regarding Idaho's HIT sustainability plan can be found in Section E of this Operational Plan.

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B.5. Goal 3: Establish seven RCs to support the integration of each PCMH with the broader Medical-Health Neighborhood.

In AY3, Goal 3 activities will focus on implementing the RC strategic plans (developed in AY2) that that can be described in four main focus areas: 1) PCMH transformation support, 2) Medical-Health Neighborhood development and connections, 3) population health initiatives, and 4) RC sustainability.

In AY2, Idaho convened the RCs for an RC Summit to discuss the RC function, value and roles, learn about population health and payer data available to the RCs and limitations on clinical data available, and to discuss RC growth and sustainability and implementation of the strategic plans. As the RCs completed their strategic plans in AY2, IDHW and the IHC determined that the RCs would benefit from seed funding to support initiation of strategic plan activities. A grant application process was developed at the end of AY2, and grants will be awarded to RCs in the first and second quarters of AY3. Grants will total approximately $250,000 a year and will be awarded for activities that support the RC's strategic plans, including sustainability, collaboration with partners, and advancement of the Medical-Health Neighborhood, and the Triple Aim.

Goal 3 activities for AY3 are described below by the RC's four main focus areas.

In AY3, Idaho will…

- Implement strategic plans for each RC which address sustainability planning and using analytic solution outputs.
- Implement evaluation plans to ensure RCs provide guidance on regional quality improvement and Medical-Health Neighborhood integration.
- Identify and address gaps in the Medical-Health Neighborhood in each region.
- PHD staff will communicate with SHIP cohort clinics regarding the supports available from RCs.
- Continue health initiatives focused on improving population health.
- Continue creating a Sustainability Plan.

Support for PCMH Transformation Process

RCs and the PHD SHIP staff support SHIP clinics in the PCMH transformation process at the local level. While both play an important role, the tasks of the RCs and the PHD SHIP staff differ.

RCs will support the SHIP cohort clinics as they transform to the PCMH model by providing a forum for the clinics to share best practices and lessons learned, and to offer peer support to each other through the transformation process. Specific examples of PCMH transformation support at the RC level includes:

- Linking SHIP cohort clinics to national, state, and local initiatives and/or best practices through a variety of mechanisms. Activities may include:
  - Connecting clinics with existing subject matter experts in the region and State
  - Establishing a drop box platform to share documents, tools, and best practices
  - Inviting SHIP cohort clinics and those working toward participation in the model to participate in trainings that occur in the region
- Developing and fostering communication opportunities for peer-to-peer support between SHIP cohort clinics and between selected clinics and those preparing for the next cohort application

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- Identifying opportunities to improve care coordination. Activities may include:
  - Establishing quarterly conference calls for care coordinators in the region
  - Supporting a care coordination director and network
  - Identifying opportunities to leverage the PCMH transformation vendor and other PHD Staff support to enhance capacity for care coordination and integration

In addition, the RCs will support PCMH transformation by conducting outreach to other practices in the region to encourage participation in the model.

The PHD SHIP staff play a pivotal role in supporting both the RCs and the SHIP cohort clinics. In working with the RCs, the PHD SHIP staff will help the RCs identify how they can most effectively support regional SHIP cohort clinics. This will include linking RCs to supports and technical assistance available through the PCMH transformation vendor, other State resources, and national learning opportunities.

The PHD SHIP staff provide on-the-ground support to the SHIP cohort clinics during the transformation process. In AY3, PHD SHIP QI Specialists will support SHIP Cohort Two clinics by providing technical assistance related to PCMH transformation and Medical-Health Neighborhood integration. These staff will also assume primary responsibility for providing technical assistance to SHIP Cohort One clinics in their second year and subsequent years of continued transformation. As PHD SHIP QI Specialists work with HMA in AY3, they will continue to gain knowledge and experience to support PCMH transformation, which is a key element of Idaho's sustainability plan for transformation efforts as well as adoption of the Virtual PCMH model by cohort clinics. PHD SHIP staff will assist with integration efforts by conducting outreach to clinics and educating potential participants about criteria for participation in the Medical-Health Neighborhood.

PHD SHIP managers will continue escalating local and regional PCMH transformation and Medical-Health Neighborhood integration issues to the RCs. For example, in AY2, RCs identified some transformation coaching processes that they felt could be improved. Discussions about improving the process led to changes to the AY3 scope of work and transformation processes. Under the leadership of RC Executive Teams and in consultation with other stakeholders as needed, RCs will continue to provide guidance and direction to PHD SHIP staff as they carry out PCMH transformation activities.

Growth and Development of Local Medical-Health Neighborhoods

A key activity of each RC will be to develop the local Medical-Health Neighborhoods. The IHC adopted the definition of a Medical-Health Neighborhood as developed by the Population Health Workgroup.

> *The Medical-Health Neighborhood is the clinical-community partnership that includes the medical, social and public health supports necessary to enhance health and the prevention of disease, with the PCMH serving as the patient's primary "hub" and coordinator of health care delivery with a focus on prevention and wellness within the context of services available outside the clinic setting. The Medical-Health Neighborhood can include: medical specialists; community services such as food, housing and transportation; dietitians; behavioral health specialists; home health; dental professionals; community health workers, community health emergency medical services, education, social services, etc. that help provide wrap-around, community-level support for the PCMH and patient to achieve better health outcomes and wellness.*

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RCs have the freedom to take different approaches to establishing and growing Medical-Health Neighborhoods in their regions but the standard definition above will be followed by all. In AY3, IDHW anticipates that most RCs will continue to push for a common understanding of the Medical-Health Neighborhood and will play a key role in strengthening the Medical-Health Neighborhood by identifying participants, building relationships in the community and addressing gaps in service areas.

The PHD SHIP staff will provide significant support to RCs as they work to develop the Medical-Health Neighborhood. In conjunction with the PHD SHIP staff, RCs will connect Medical-Neighborhood participants at regularly scheduled RC meetings and provide a structured forum for sharing valuable knowledge, finding common solutions, and identifying resources.

Specific examples of activities that RCs and PHD SHIP staff will carry out to support growth and development of the Medical-Health Neighborhood include:

A. Surveying SHIP cohort clinics on the partnerships needed to improve care coordination and facilitate connections with those Medical-Health Neighborhood participants.

B. Mapping care communities and reviewing membership to ensure full representation and participation across the local Medical-Health Neighborhood.

C. Contributing local knowledge and expertise in strengthening care coordination opportunities between the SHIP cohort clinics and the Medical-Health Neighborhood.

D. Developing a Medical-Health Neighborhood website for resource identification and sharing.

E. Hosting educational opportunities at RC meetings, including engaging state and national subject matter experts to speak.

F. Identifying resources in the community and working to improve efficiency and effectiveness of referrals. For example, the RC might invite transportation vendors to educate the group on most common reasons transportation requests get denied and the information required in 80% of referral forms. Following the meeting, notes will be shared on the Medical-Health Neighborhood and/or SHIP website to share information with other SHIP cohort clinics and RCs.

A list of Medical-Neighborhood participants in each region was developed at the end of AY2 and will be used to measure growth in amount and type of participants. RCs will work with PHD staff to assess the diversity of the participants in the Medical-Health Neighborhood and identify participant types that are underrepresented in the Medical-Health Neighborhood. Since one of the RCs' goals is to build a Medical-Health Neighborhood that suits the needs of the individuals, RCs will work with PHD staff to reach out to potential participants to invite them to discuss potential collaboration.

To further support RCs in their role of developing the Medical-Health Neighborhood, IDHW will continue to expand awareness and knowledge around Medical-Health Neighborhoods, including working with the Population Health Workgroup to develop a communication plan and materials to advance Medical-Neighborhood integration efforts.

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Regional Population Health and Quality Improvement Initiatives

A third focus area for RCs, with the support of the PHD SHIP staff, is to improve local population health and, in doing so, contribute to the state's overall health improvement. In addition to population health strategies, RCsand PHD SHIP staff will work with SHIP cohort clinics and Medical-Health Neighborhood participants to improve care delivery through quality improvement initiatives that aim to strengthen care coordination and expand best practices in clinical care.

In AY3, PHD SHIP staff, leveraging regional resources and expertise, will work with local providers and community-based organizations to conduct community health assessments. The community assessment will be used to identify population health and clinical quality improvement initiatives to address regional health needs. The community assessment will be developed by PHDs and will be based on information from:

- **The 2017 *Get Healthy Idaho* plan**[19]. In AY2, to support population health initiatives at the regional and state level, IDHW and the IHC worked to ensure that SIM activities were aligned with and contributed to the population health improvement goals outlined in *Get Healthy Idaho: Measuring and Improving Population Health.* The IHC placed particular emphasis on supporting efforts to alleviate the top four major population health concerns identified through *Get Healthy Idaho's* population health improvement plan:
    A. Access to care
    B. Adult and childhood obesity
    C. Tobacco use
    D. Diabetes

    With input from the Population Health Workgroup, IDHW's Division of Public Health is in the process of completing an annual update *to Get Healthy Idaho's* population health improvement plan. The process is expected to be completed in the first quarter of AY3. When complete, the plan will be shared with the IHC and other stakeholders involved with healthcare transformation and public health. The plan fulfills requirements for SHIP and the Division of Public Health's accreditation process. The Division of Public Health will create regional population health dashboards displaying available data on leading health indicators at the regional level. A data visualization website will be finalized to display population and public health data.

- **CQM data analytics.** In AY2, the IHC's CQM Workgroup and HIT Workgroup chose four quality metrics for initial measurement due, in part, to their alignment with the four priority areas listed above from the *Get Healthy Idaho* plan. Of the sixteen metrics in Idaho's Clinical Quality Measure Catalog, the four quality metrics selected for initial measurement are:
    A. Tobacco use

[19] Get Healthy Idaho: Measuring and Improving Population Health, April 2015. http://www.healthandwelfare.idaho.gov/Portals/0/Health/Get%20Healthy%20Idaho%20%20Measuring%20and%20Improving%20Population%20Health%20%20%20April%202015%20(2).pdf

Statewide Healthcare Innovation Plan (SHIP) is supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

B. Weight assessment and counseling for children and adolescents
C. Adult body mass index assessment
D. Diabetes care

Data analytics reports on these measures will be the product of Goal 5 activities. In AY3, IDHW will make reports on these measures available to the RCs.

- **Inventory of select statewide quality improvement initiatives that are occurring in each of the SHIP cohort clinics.** The Division of Public Health created this inventory in AY2 of the QI initiatives being implemented at the clinic level, and plans to expand the inventory to include SHIP Cohort Two practices in AY3.

- **CHEMS agencies community assessment.** Goal 4 activities include the development of CHEMS personnel and agencies in Idaho. As part of these activities, CHEMS students will conduct a community assessment, using the sponsoring agency's service area as the catchment boundary. This assessment provides a description of the community through the CHEMS lens, and may include qualitative and quantitative data. The dimensions of inquiry might include the following; population, history, physical attributes, infrastructure, socioeconomics, demographics, education, employment, housing, government programs and resources, obesity, morbidity and mortality, tobacco use, pregnancy and motherhood, violent crime, drug and alcohol use, immunization rates, access to primary and mental health care, food insecurity etc. The assessment may also include a description of priorities and service gaps that could potentially be filled by community paramedics.

- **Other sources, including, but not limited to, the Behavioral Risk Factor Surveillance System, the Youth Risk Behavior Survey, vital records, immunization data, prescription drug monitoring program data, local surveys, etc. Examples of additional information available in AY3 to SHIP managers as they develop the community assessment include:**

In AY2, the RCs began explore regional population health and quality improvement activities; this involves coordinating existing initiatives and funding streams to support health outcome improvement. For example, in District 1, the RC Executive Team placed a focus on opioid prescribing and fluoride varnish. District 7 will be focused on developing referral resources and pathways for communication. In AY3, the RCs will continue working with PHD SHIP staff, SHIP cohort clinics and regional Medical-Health Neighborhood participants to complete the community assessment and determine their local population health and quality improvement activities. Each RC will use its own process for selecting initiatives that improve quality and population health. RC initiatives do not automatically include SHIP funding. In AY3, RCs will be able to access a competitive RC funding process to support initiatives in which a critical component of infrastructure is absent and no other resources are available. Because of the varied nature of RC initiatives, additional information will be available once applications are received and considered for funding. Preliminary information regarding the funding process is described below (in "RC AY3 Grant Program").

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In AY3, the RCs will also work with PHDs, SHIP cohort clinics, and Medical-Health Neighborhood participants to implement population health and quality improvement activities as outlined in their strategic plans.

This work at the RC level will continue to be supported by the Population Health Workgroup, which is co-chaired by Elke Shaw-Tulloch, Administrator of the Division of Public Health and Lora Whalen, PHD Director for Panhandle District Health (District 1). Even though each RC has a direct tie to the IHC via their executive leadership team (comprised of two physicians and the PHD Director), the IHC forum is not ideal for RC-level discussions given the diversity of policy topics addressed at the IHC level. Instead, the Population Health Workgroup offers optimal stakeholder representation and the ability to have discussions and provide support for RCs at a policy and operations level. Through its monthly meetings, the Population Health Workgroup identifies opportunities for public health and primary care integration within the RCs — a component of their strategic plans. RC representatives (PHD staff, members and stakeholders) share updates, learn from each other, hear presentations from representatives of health initiatives and population health resources across Idaho, and develop strategies to integrate and align initiatives at the regional level. In AY3, the Population Health Workgroup will continue to provide a forum for supporting RC efforts to identify and align public health and primary care programming to improve health outcomes statewide.

RC Sustainability Planning

A final focus of RC's strategic planning in AY2 was the development of a sustainability plan. RCs are initially focused on building a membership that can carry out the work of the RC and eventually garner resources through partnerships and other resources to maintain RC functions. Activities for AY3 toward sustainability building include:

- Evaluating current membership to establish appropriate representation.
- Identifying additional community partners to support the RC.
- Educating others on the mission of the RC to engage and commit others to the work.

RC AY3 Grant Program

Recognizing the unique perspective, autonomy and activities of each RC is foundational for success of SHIP. Based on feedback and recommendations from the IHC, the budgets to support Goal 4 have been restructured to include a granting program of $250,000 which allows each RC the opportunity to apply for funding to support their various AY3 activities and initiatives. Since each RC is not a fiscal entity with fiduciary capacity, the PHD shall act as the recipient entity and administer the funding according to the approved award (via subgrant). The process will include the following:

- Applications may be up to 5 pages in length; 3 pages for the required scored criteria and 2 pages for the required non-scored criteria.
- Submitted in single spaced, 11 point Calibri font, one inch margins.
- Must include a detailed budget and narrative, which does not count against the page limit.
- Applicants are required to respond to questions and clarifications about the submission in a reasonable amount.

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- Final grant recipients will be required to report regularly on the project initiative(s).

Applications will be reviewed by a multi-disciplinary team of IDHW staff on the following criteria:

A. Alignment with the RC Strategic Plan
B. Advancement of the Medical-Health Neighborhood concept
C. Demonstration of innovation, replicability, and scalability
D. Sustainability beyond the funding period
E. Alignment with the triple aim
F. Stakeholder involvement and support
G. Allowable costs under the CMMI Notice of Award and Office of Acquisition and Grants Management (OAGM) guidelines

Funding for the RCs is anticipated to commence at the start of AY3 pending OAGM and CMMI approval.

Other Activities to Support Attainment of Goal 3

The Population Health Workgroup has accepted the task of developing a toolkit of communications materials for use by the RCs, PHD SHIP staff, and IHC members to communicate with Medical-Health Neighborhood participants in AY3. These materials will define the important role of the Medical-Health Neighborhood in Idaho's transformation and will provide information on the relationship between Medical-Health Neighborhood participants, the RCs, and SHIP cohort clinics. It is expected that the toolkit will include a variety of communications materials and may include fact sheets and posters for clinics to display in their lobby, if appropriate.

RCs will continue to work at the regional level to increase alignment between SHIP and other local, state and federal initiatives. This work will build upon alignment that was created in 2016. Below are some examples of alignment that was created at the RC level in 2016:

- **Idaho Oral Health Alliance**. The alliance named dentists to work with five RCs and began work to develop oral health networks to identify local oral health concerns and needs. More information about the Idaho Oral Health Alliance can be found at http://www.idahooralhealth.org/.
- **Maternal and Child Health.** The Maternal and Child Health Program continues to support Eastern Idaho PHD in providing care coordination services for children with special health care needs. The PHD provides care coordination for these more complex patients in three clinics to support their PCMH transformation.
- **Idaho Academy of Nutrition and Dietetics**. The Academy created a resource directory of dieticians in the state and areas of specialties to help support SHIP clinics and the RCs.

No regulatory or legislative changes are expected to impact Goal 3 in AY3.

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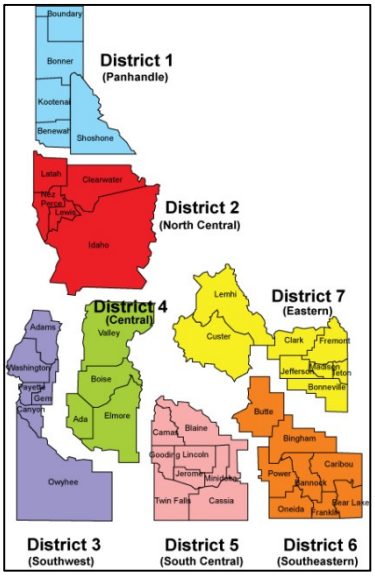
B.6. Goal 4: Improve rural patient access to PCMHs by developing Virtual PCMHs.

The Virtual PCMH model is an important component of Idaho's efforts to expand access to the PCMH team-based model. The Virtual PCMH is an innovative model tailored to Idaho that maximizes and creates new community resources while broadening outreach to rural, medically-underserved communities. The aim of Goal 4 is to implement Virtual PCMHs in Idaho.

The majority of AY2 activities related to Goal 4 were focused on procuring contractors to develop curricula and provide training for CHWs and CHEMS personnel and establishing Virtual PCMH requirements, standards, and the designation process. In AY3, Idaho will begin to implement the core components of the Virtual PCMH model — telehealth technology, CHWs, and CHEMS. Virtual PCMHs will receive a reimbursement payment to further support their implementation of these core components.

In AY3, Idaho will…

- Continue to recruit clinics to become Virtual PCMHs.
- Distribute reimbursement payments for Virtual PCMHs that meet criteria.
- Continue recruiting and engaging CHEMS.
- Continue recruiting and engaging CHWs.
- Amend contract to continue CHW training and expand offerings as needed.
- Develop and implement new telehealth programs in SHIP



CHWs

In AY3 Idaho will continue to recruit and train CHWs. Partnering with the Bureau of Community and Environmental Health, the IDHW SHIP team will continue marketing and educational activities for CHW roles. In 2016, the Bureau of Community and Environmental Health's Outreach and Education Subcommittee prepared video marketing materials working with CHWs, physicians, and administrators to promote use and training of CHWs. In AY3, these materials will be widely distributed to promote clinic engagement of CHWs as a component of the Virtual PCMH model.

In AY3, Idaho State University will continue to provide a 16-week CHW training course using the curriculum established during AY2. In AY2, Idaho recruited 23 candidates (11 completed training and 12 engaged to begin training) for CHW training, short of the year's goal of 25 candidates. As a result of this experience, Idaho modified its goal for CHW training down from 200 CHWs to 125 CHWs by the end of AY4. The primary factor in reducing this goal was limited funding sources to pay for CHW services, which is a challenge to expanding this component of the Virtual PCMH model. Idaho hopes to have discussions with payers in AY3 regarding payment methodologies for CHWs that will facilitate increased interest and engagement.

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Idaho is still committed to developing CHWs, as national studies have shown that CHWs can be effective in reaching individuals who are isolate due to their geographic location, transportation needs, or cultural differences. In AY3, IDHW will work with SHIP cohort clinics and other primary care clinics to identify ways for clinics to integrate CHWs in their work flows.

CHEMS

CHEMS personnel provide primary care and preventative services in the community, including vaccinations, medication inventories, resource coordination, basic medical therapeutics, and transitional care for patients after a hospital discharge. The CHEMS approach employs currently available and often underutilized healthcare resources to provide services that help improve access to care in medically underserved communities. In AY3, Idaho will continue to develop infrastructure to train EMS personnel and agencies.

In AY3, Idaho will also continue to engage SHIP cohort clinics in utilizing CHEMS personnel as an important component of the Virtual PCMH model. IDHW will continue to educate SHIP cohort clinics on the value of CHEMS to change health outcomes. Each clinic will have the flexibility to establish referral patterns and engage CHEMS agencies in a way that works for their practice. CHEMS agencies will also be expected to outreach to SHIP cohort clinics and establish working relationships to coordinate the delivery of care.

In AY2, IDHW engaged a contractor to develop training, conduct outreach to EMS agencies across the state, and enroll students to become CHEMS personnel. In AY2, the first cohort of 10 community paramedic students will complete their second semester of advanced life support training in December at Idaho State University. The course fee is funded by the Idaho Bureau of Emergency Medical Services and Preparedness. A new cohort of community paramedic students will begin CHEMS training in January 2017.

In AY3, Idaho will expand CHEMS training to include basic life support (BLS) and intermediate life support (ILS) training for emergency medical technicians. IDHW will contract with a training contractor to develop the training. This training will help develop more CHEMS personnel with the skills and expertise to provide primary and preventative care for hard to reach populations in medically underserved areas. Based on training experience and lessons learned from CHEMS agencies in AY2, Idaho revised the success measure associated with CHEMS personnel training. By AY4, a total of 35 CHEMS personnel will be trained (revised from 52), and it is Idaho's goal that the majority of trained personnel become active participants in delivering care in the community before the end of AY4.

In addition to training activities to increase the number of CHEMS personnel, Idaho will also work to increase the number of EMS agencies with CHEMS programs. In AY2, with the support of the Division of Public Health, university representatives, and EMS agencies, IDHW engaged Ada County Paramedics to provide technical assistance and peer mentoring to EMS agencies interested in building CHEMS programs. A multi-day workshop was conducted early in AY2. In AY3, Ada County Paramedics will continue efforts to refine internal and external engagement templates, tools, and resources to be used by CHEMS agencies statewide to recruit CHEMS personnel. Ada County Paramedics will also continue to assist the CHEMS Workgroup in developing a report of CHEMS-identified outcome measures, data collection, and reporting strategies.

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As with CHWs, Idaho faces challenges in engaging CHEMS agencies due to lack of funding sources to pay for services provided by CHEMS personnel. However, CMMI agreed to repurpose up to $10,000 per CHEMS agency to support CHEMS program development and implementation activities such as recruitment, community outreach strategy, clinical rotation for paramedics, and submission of measured data. These funds will be distributed in AY3 and IDHW hopes these funds will pique the interest of EMS agencies.

IDHW and its stakeholders also worked in AY2 to begin developing metrics and a data flow to support evaluation of the value and impact of CHEMS programs. In AY3, Idaho will finalize the CHEMS metrics and data flow. Idaho anticipates that CHEMS personnel will begin collecting data in AY3 using tablets that will be provided for this purpose. Data will be collected using a HIPAA-compliant survey platform. Once a month, the tablets will transmit data to HTS, the data analytics vendor. HTS will analyze the data and produce dashboard reports. These reports will be shared with the IDHW SHIP team and the CHEMS Workgroup and will be used to assess the success of the CHEMS program. In AY3, CHEMS activities will be supported by a new CHEMS Workgroup. In April 2016, the former CHEMS Advisory Group was transitioned into a Workgroup because the responsibilities of the former CHEMS Advisory Group were either completed or shifted to a different group. The new CHEMS Workgroup will retain most of the CHEMS Advisory Group's members, in addition to new members from EMS agencies across the State, universities, payers, and hospitals. The CHEMS Workgroup meets weekly and includes a variety of stakeholders with statewide representation.

Telehealth

In AY2, the Telehealth Council created a subcommittee to further promote alignment between SHIP telehealth activities and broader statewide telehealth efforts. While the Telehealth Council continues its mission of advising the IHC on policy matters, the subcommittee has assumed responsibility for coordinating telehealth activities related to SHIP. In AY3, the subcommittee will continue to be involved in the work related to telehealth as Idaho continues to explore ways to optimize telehealth technology to implement delivery system reform.

Idaho completed two major milestones in AY2 that are critical to advancing the telehealth component of the Virtual PCMH in AY3. Early in AY2, Idaho developed a telehealth expansion and implementation plan and HMA was selected as the telehealth contractor to provide a telehealth curriculum to primary care clinics to enhance capacity in specialty care and behavioral health service delivery. Training and education will continue through the end of AY2, enabling SHIP cohort clinics to use what they have learned to prepare proposals for telehealth implementation as part of the Virtual PCMH model. In AY2, Idaho also finalized and released the telehealth grant application for SHIP Cohort One clinics and will accept applications from SHIP clinics that want to receive financial and technical assistance in incorporating telehealth in their clinic.

At this time Idaho is focused on implementing telehealth at SHIP clinics in underserved areas. The criteria for the telehealth component of Virtual PCMH designation are weighted appropriately to seek SHIP clinics in rural areas. All applications submitted by the end of the application period will be reviewed and awarded by the beginning of AY3. Idaho will work with CMMI to release funds and distribute them to successful applicants beginning in the first quarter of AY3. Recipients will use the

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funds to implement the model described in their proposals. IDHW will develop a plan to monitor the contracts with each clinic and collect information regarding measures and status of implementation.

Idaho is also establishing telehealth programs at EMS agencies. EMS agencies will be able to apply for grant funding to implement telehealth equipment. Agencies will submit a written proposal for review and potential award.

In AY3, Idaho will continue to explore the possibility of establishing an Extension for Community Healthcare Outcomes (ECHO) site in Idaho. The state faces challenges to establishing an ECHO site, however, due to the lack of medical schools in the state. Idaho will focus attention on exploring how ECHO can be implemented in Idaho and engaging technical assistance in this effort.

The table below summarizes the key telehealth activities described above.

Table 12 - AY3 Telehealth Activities

Activity (telehealth functionality or activity)	Geographic Limitations	Barriers	Funding Source	Timeline
Implement PCMH telehealth grant application and secure funding from CMMI.	None. SHIP clinics in any region of the state can apply.	Lack of resources (IDHW SHIP)	SIM Test funds	December 2016–April 2017
Implement PCMH telehealth grant initiatives.	None. SHIP clinics in any region of the state can apply.	Lack of resources (IDHW SHIP)	Repurposed SHIP funds $10,000 per SHIP clinic (pending CMMI approval)	April 2017–end of grant period
Monitor PCMH telehealth grant initiatives implementation.	None. SHIP clinics in all regions of the state will be monitored.	Lack of resources (IDHW SHIP)	SIM Test funds	April 2017 (ongoing)
Design CHEMS telehealth program.	None. CHEMS programs in any region of the state will be eligible.	Lack of resources (IDHW SHIP)	SIM Test funds	April 2017–May 2017
Implement CHEMS telehealth grant application and secure funding from CMMI.	None. CHEMS programs in any region of the state can apply.	Lack of resources (IDHW SHIP)	SIM Test funds	May 2017–end of grant period

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Activity (telehealth functionality or activity)	Geographic Limitations	Barriers	Funding Source	Timeline
Implement CHEMS telehealth grant initiatives.	None. CHEMS programs in any region of the state can apply.	Lack of resources (IDHW SHIP)	SIM Test funds	September 2017 (ongoing)
Monitor CHEMS telehealth grant initiatives implementation.	None. CHEMS programs in all regions of the state will be monitored.	Lack of resources (IDHW SHIP)	SIM Test funds	September 2017 (ongoing)
Continue exploring options for implementation of ECHO.	None.	Lack of resources (IDHW SHIP)	SIM Test funds	Ongoing

Expanding Workforce Capacity

As with Goal 1, Goal 4 activities are also aimed at increasing workforce capacity in Idaho by establishing the three components of the Virtual PCMH model: CHWs, CHEMS, and telehealth. Engaging these resources will increase access to primary and preventative care, especially in medically underserved and rural areas.

The need for these resources is particularly acute due to the physician workforce shortage in Idaho. In 2016, the Idaho State Board of Medicine and the Idaho Department of Labor collaborated on a study that used Idaho Department of Labor Employment data to better understand the physician workforce in Idaho. This collaboration was enabled by State House Bill 211, passed in 2013, which allowed data sharing between these two entities. The legislation and resulting study begins to remedy a historical disconnect in Idaho: the Board of Medicine licenses physicians, but does not have information on where they work, while the Department of Labor knows who is working in Idaho, but does not know who is a physician.

The results of the study enable a more precise understanding of the physician workforce in Idaho. The study shows where physicians in the State of Idaho are employed (in rural or urban areas and by county), as well as their age and specialty. The study found there are 2,132 physicians and surgeons working in Idaho. This study may be used in AY3 as Idaho identifies under-resourced areas to target for Virtual PCMHs.

Another important analysis of healthcare workforce data in 2016 that will be used in AY3 was the Bureau of Rural Health's Primary Care Needs Assessment. The purpose of the assessment was to, "identify communities with the greatest unmet health care needs, disparities, and health workforce

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shortages across Idaho, and identify key barriers to health care access for Idaho communities in terms of preventative and primary care."[20]

The assessment reviewed data from sources presented above such as the Association of American Medical Colleges and Health Resources and Services Administration. The assessment found that, "while current federal shortage designations are valuable in determining provider shortage serving a geographic area or population, these designations alone do not necessarily provide an accurate assessment tool for identifying or indicating geographic areas or population groups with a deficit of primary care service."[21]

Idaho anticipates legislative action in AY3 to help address workforce capacity gaps. Idaho is planning to request funding for loan repayment programs. If successful, this may positively influence the recruitment and retention of physicians in Idaho. Idaho will continue to pursue this solution in AY3 in addition to the activities described in Goal 1.

[20] http://healthandwelfare.idaho.gov/Portals/0/Health/Rural%20Health/2016%20IDAHO%20PRIMARY%20CARE%20NEEDS%20ASSESSMENT.pdf

[21] http://healthandwelfare.idaho.gov/Portals/0/Health/Rural%20Health/2016%20IDAHO%20PRIMARY%20CARE%20NEEDS%20ASSESSMENT.pdf

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B.7. Goal 6: Align payment mechanisms across payers to transform payment methodology from volume to value.

In AY3, Idaho will…

- Collect data from payers to track progress toward paying for value.
- Analyze data and report progress to IHC.

Idaho has garnered the support and participation of commercial payers through genuine appreciation and understanding of each payer's need to design and implement alternatives to FFS payment models that they believe will be most effective for their patients and providers and that fits within their organization's goals. Payers have different perspectives on which value-based purchasing payment models will work for them. The IHC and IDHW understand that the shift from alternatives to FFS to value-based purchasing will only occur across payers if payers are driving the change rather than feeling forced to adopt specific models wholesale. Idaho's largest commercial payers have come willingly to the table to participate in SHIP, but it must be understood that the movement to value-based purchasing and the sharing of information by payers with other payers requires a significant shift in the way things have been done historically. Transformation of this nature is occurring, and in AY3, Idaho's payers will continue to shift their payments for health care services from those that incentivize volume of care to models that incentivize the value of care.

The baseline payer data collected and analyzed by Mercer in AY2 will provide information on what alternatives to FFS models are increasing across payers. In AY3, Idaho will report the baseline payer data to the IHC. The second year of annual data from commercial payers, Medicare, and Medicaid will also be collected in AY3. In AY4, Idaho will be able to produce the first report that shows the progress in shifting from FFS to other models and which models payers have chosen as they shift to value-based purchasing.

To begin collecting payer data needed to track Idaho's progress in shifting to alternatives to FFS arrangement, an Idaho alternative payment model framework was developed by the Multi-Payer Workgroup that follows the model developed by the Health Care Payment Learning and Action Network model[22]. The framework delineates a continuum that advances from FFS to value-based payment strategies as shown in the graphic below. The framework reflects the different payment methodologies in the Idaho marketplace.

[22] The Health Care Payment Learning and Action Network was established by the U.S. Health & Human Services Department to create a forum for public-private entities to exchange best practices regarding how to transition to alternative payment models that emphasize value. More information can be found at https://innovation.cms.gov/initiatives/Health-Care-Payment-Learning-and-Action-Network/.

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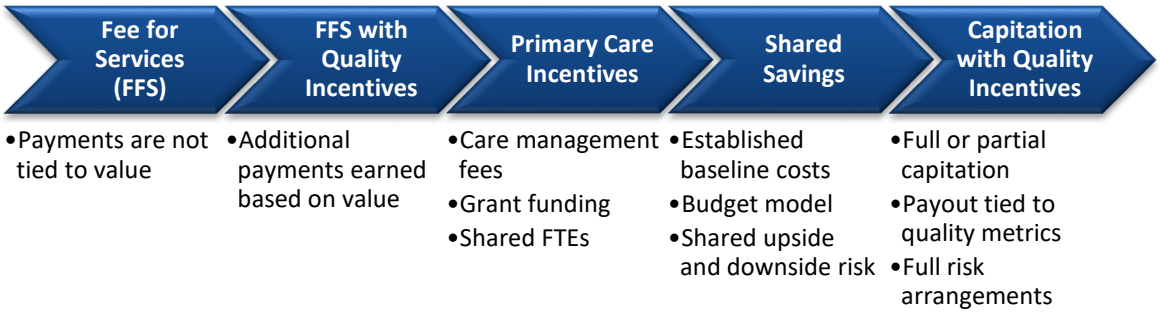
Figure 10 – Payer Reporting Framework



In AY2, Idaho began collecting data from Medicaid, Medicare, and three of the four largest commercial payers in the state regarding payments made across the five payment models in the framework. Data was submitted using a common reporting template developed in collaboration with payers. The template presents a continuum for payers to report the following data for calendar year (CY) 2016 across all lines of business:

- Percentage of beneficiaries per payment structure, e.g., FFS, FFS with quality incentives, etc.
- Total percentage of payments (paid or accrued) to providers per payment structure.
- Total payments paid to providers.

In AY3, Mercer will analyze the data provided by payers in AY2. The results of the analysis will then be presented to the IHC in AY3.

The data will be submitted in the second half of CY 2017 for the period of January 1–December 31, 2016. After signing a non-disclosure agreement with Mercer, payers will submit aggregate data to Mercer who will then aggregate data across the payers for reporting to IHC. Mercer will collect data from payers in part to ensure the privacy of payer data. Financial data reported in AY3 will be compared to financial data in AY2 to measure the progress of statewide payment transformation.

In AY3, the IHC and IDHW will continue to work with its payers, primarily through the Multi-Payer Workgroup but also on a one-to-one basis, to support and accelerate the transition from FFS payments to alternative value-based payments. The reports produced by HTS will allow payers to see performance results across regions and provider networks. This new information will be used by payers to identify areas that should be targeted for value-based payment arrangements in order to create financial incentives to improve care. IDHW SHIP and Medicaid will continue to participate in the Health Care Payment Learning and Action Network to bring forth ideas to faciliate further advancement of value-based payment approaches.

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B.8. Goal 7: Reduce overall healthcare costs.

In AY3, Idaho will…

- Collect data from payers needed to conduct the cost savings analysis and return on investment.

In AY3, IDHW will collect payer cost data, as described below, for use in measuring the overall cost savings during the Model Test and for calculating the return on investment for CMMI's support of Idaho's health system transformation through the SIM grant.

Measurement of cost-savings is long term, and the true impact of implementing Idaho's Model Test will be measured annually through the Model Test period and subsequently thereafter to allow for claims run-out.

In AY3, Mercer will perform an analysis of payer data collected in AY2. Payers will also be asked for their next annual data submission. Specifically, payers will report membership and expense data for CY 2016 across their lines of business using the financial reporting template developed in 2015. The reporting template will ask payers to report data according to the groups shown in the table below:

Table 13 – Payer Groups

Medicaid/ CHIP	Commercial/ Private/Other	Medicare
• Adult • Child • Dual Eligibles (Only) • Disabled/Elderly (Without Duals)	• Individual • Family	• Dual Eligible • FFS/Non-Duals (Parts A and B) • Medicare Advantage Part C

More specifically, the reporting template will ask payers to classify and report their expense data within each group by the following categories of service:

- Inpatient Hospital
- Emergency Department
- Urgent Care
- Professional Primary Care
- Professional Specialty Care
- Diagnostic Imaging/X-Ray
- Laboratory Services
- Dialysis Procedures
- Outpatient Hospital
- Professional other (e.g., Physical Therapy, Occupational Therapy)
- Skilled Nursing Facility
- Home Health
- Home and Community-Based Services
- Other costs not described elsewhere
- Behavioral Health
- Prescription Drugs (Outpatient)
- Durable Medical Equipment
- Intermediate care facilities for individuals with mental retardation

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C.Detailed SIM Operational Work Plans by Driver/Goals

C.1. Goal 1

Milestone/Measure of Success	Budget Activity	Action Steps necessary to complete activity (HOW)	Timeline (expected date of implementation)	Expenditures and Responsible Party (e.g., State, vendor, etc.)
Cohort Three recruitment plan	Implement Cohort Three recruitment plan	- Evaluate recruitment plan for Cohort Two. Make adjustments as needed. - Seek stakeholder review. - IHC approves recruitment plan. - Implement Cohort Three recruitment plan.	Recruitment plan implementation to begin 6/30/2017	IDHW, IMHC and IHC $55,412
Cohort Three SHIP clinic selection criteria and process	Publish Cohort Three selection criteria and process	- Review Cohort Two selection criteria and process. Edit as needed for Cohort Three. - Seek stakeholder review. - IHC approves selection criteria and process. - Publish selection criteria and process so that primary care clinics are aware of the criteria and process.	Criteria/process to be published by 9/15/2017	IDHW, IMHC and IHC $55,412
Interest survey	Administer interest survey	- Review Cohort Two interest survey. Edit as needed for Cohort Three. - Seek stakeholder review. - IHC approves interest survey. - Implement Cohort Three interest survey. - Clinics submit interest survey.	Clinics submit interest survey by 9/30/2017	IDHW, IMHC, IHC and primary care clinics $55,412

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Milestone/Measure of Success	Budget Activity	Action Steps necessary to complete activity (HOW)	Timeline (expected date of implementation)	Expenditures and Responsible Party (e.g., State, vendor, etc.)
Final PCMH application	Implement Cohort Three final PCMH application	- Review Cohort Two final PCMH application. Edit as needed for Cohort Three. - Seek stakeholder review. - IHC approves final PCMH application. - Clinics submit final PCMH application. - IDHW reviews final PCMH applications and selects clinics to participate in SHIP Cohort Three.	Selection of Cohort Three clinics by 12/15/2017	IDHW, IMHC IHC and primary care clinics $55,412

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Milestone/Measure of Success	Budget Activity	Action Steps necessary to complete activity (HOW)	Timeline (expected date of implementation)	Expenditures and Responsible Party (e.g., State, vendor, etc.)
Readiness assessment and Transformation Plan.	Conduct readiness assessments and develop Transformation Plans for Cohort Two clinics.	- Review the readiness assessment and Transformation Plan template established by Briljent for Cohorts One and Two. Edit as needed for Cohort Three. - Seek stakeholder review (including from Briljent). - IHC approves readiness assessment and Transformation Plan template. - Cohort Three clinics submit readiness assessment as part of their final PCMH application. - After selection, clinics work with their HMA coach to complete a Transformation Plan. - HMA coaches, PHD staff, and clinics update their Transformation Plans to document progress toward transformation goals.	Clinics complete Transformation Plan by 4/3/2017	Briljent, IDHW, IHC, Cohort Two clinics, HMA, PHD staff $341,564
Process for distributing financial reimbursement to qualifying clinics.	Distribute financial reimbursements and implement fraud/abuse protections.	Myers and Stauffer implements reimbursement distribution process using IPAS.	Varies depending on type of incentive payment	Briljent $341,564
	Recoup reimbursement payments for clinics that did not meet the technical support benchmarks for retaining the payment.	- Determine if any clinic did not reach benchmark. - Determine if any clinic failed to submit appropriate reimbursable activities. - Recoup payment.	Recoupment will occur by 2/1/2018	Briljent $341,564

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Milestone/Measure of Success	Budget Activity	Action Steps necessary to complete activity (HOW)	Timeline (expected date of implementation)	Expenditures and Responsible Party (e.g., State, vendor, etc.)
Ongoing stakeholder communications regarding SHIP cohort clinics.	Continue development and implementation of tailored communications materials to internal and external stakeholders.	- Develop communication materials as needed. - Implement communications materials.	Ongoing	IDHW, IHC $55,412
Technical support and mentoring to clinics.	Continue implementation of technical assistance program.	- Cohort Two clinics participate in coaching calls, site visits, learning collaboratives, and webinars provided by HMA and PHD Staff. - Cohort Two clinics use the transformation portal to complete and update Transformation Plan and share documentation.	2/1/2017 through 1/31/2018	HMA, PHD staff, Cohort Two clinics $1,024,691
	Support PCMHs in connecting to IHDE and submitting quality measurement data.	See Goal 2 table.	2/1/2017 through 1/31/2018	IHDE, Cohort Two clinics $435,562

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C.2. Goal 2

Milestone/Measure of Success	Budget Activity	Action Steps necessary to complete activity (HOW)	Timeline (expected date of implementation)	Expenditures and Responsible Party (e.g., State, vendor, etc.)
Build connections between IHDE and SHIP clinics.	Evaluate and enhance connections with Cohort One clinics. Build connections with Cohort Two clinics.	- Build Cohort One clinic connections that were not completed during in AY2. - Complete enhancements to Cohort One clinic connections for the first four clinical quality measures. - Enhance Cohort One clinic connections for the next set of six clinical quality measures. - Assist Cohort One clinics in working through data quality improvements for measures 1–10. - IHDE and Cohort Two clinics sign a business agreement. - IHDE grants the clinic "view-only" access to clinical portal. - IHDE conducts training with Cohort Two clinics. - Distribute readiness assessment to Cohort Two clinics. - Clinics complete readiness assessment. - IHDE builds clinic connection to IHDE. - HTS conducts a gap analysis. - Additional builds to fill the gaps.	2/1/2017 through 1/31/2018	IHDE, IDHW, Cohort Two clinics $1,146,926
	Prepare for connections with Cohort Three clinics.	- Revise business agreement, readiness assessment, and training as needed.	Preparations to begin on 10/15/2017	IHDE, IDHW $510,542
Distribute payment of EHR fees.	Distribute payments to Cohort One clinics EHR vendor.	- Determine amount of payment per clinic via IHDE readiness assessments. - Make payment to EHR vendor via IHDE.		IHDE, IDHW $527,189

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Milestone/Measure of Success	Budget Activity	Action Steps necessary to complete activity (HOW)	Timeline (expected date of implementation)	Expenditures and Responsible Party (e.g., State, vendor, etc.)
	Distribute payments to Cohort One clinics EHR vendor.	- Determine amount of payment per clinic via IHDE readiness assessments. - Make payment to EHR vendor via IHDE.		IHDE, IDHW $567,585
Build connections between hospitals and IHDE.	Work with hospitals and IHDE to establish connections.	- IHDE will build hospital connections.		IHDE, hospitals N/A
Align SHIP HIT activities with the Statewide HIT plan.	Continue work to align Goal 2 activities with Idaho's statewide HIT plan.	- Coordinate with team drafting statewide HIT plan. - Implement activities to align Goal 2 activities with statewide HIT plan.	2/1/2017 through 1/31/2018	$231,366
Evaluate enhancements to IHDE.	Determine next steps and implement as appropriate.	- Review results of feasibility study regarding connections between IHDE and regional databases. - Implement additional activities as appropriate.	2/1/2017 through 1/31/2018	$200,000

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C.3. Goal 3

Milestone/Measure of Success	Budget Activity	Action Steps necessary to complete activity (HOW)	Timeline (expected date of implementation)	Expenditures and Responsible Party (e.g., State, vendor, etc.)
Integrate Medical-Health Neighborhoods.	Identify and address gaps in participants in the Medical-Health Neighborhood in each PHD.	- Assess the list of Medical-Health Neighborhood participants to identify gaps. - Distribute the list of Medical-Health Neighborhood participants to IDHW and SHIP clinics.	March 2017	PHDs $420,000
	Communicate with SHIP clinics regarding the support available from RCs.	- Develop communication. - Review/revise communication. - Finalize communication.	January 2017	PHDs $420,000
RCs provide regional quality improvement guidance.	Implement strategic plans for each RC.	- Develop plans. - Share plans with stakeholders for feedback. - Implement plans.	Begin implementing plan on 2/1/2017	PHDs $420,000
	RC grants.	- Develop and implement grant program to support RCs. - Award grants to support RCs.	Begin awarding grants in March 2017	PHDs $420,000

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C.4. Goal 4

Milestone/Measure of Success	Budget Activity	Action Steps necessary to complete activity (HOW)	Timeline (expected date of implementation)	Expenditures and Responsible Party (e.g., State, vendor, etc.)
Designate clinics as Virtual PCMHs.	Implement Virtual PCMH recruitment plan.	- Revise recruitment plan. - Share with stakeholders for feedback. - Implement recruitment plan.	11/22/2016 through 5/31/2017	IDHW $77,784
	Designate Virtual PCMHs.	- Conduct selection/designation process.	12/29/2016 through 5/31/2017	IDHW $77,784
	Provide reimbursement payments for Virtual PCMHs.	- Send information to Briljent to distribute payment.	12/29/2016 through 5/31/2017	IDHW, Briljent $77,784
Build infrastructure for CHEMS.	Establish training programs for CHEMS, focusing on requirements for BLS/ILS.	- Develop curriculum. - Conduct training.	1/3/2017 through 5/1/2017	$77,784
	Continue supporting CHEMS activities.	- CHEMS Workgroup meetings and associated activities.	2/1/2017 through 1/31/2018	CHEMS Workgroup $77,784
	Provide funding to CHEMS agencies to support program development and implementation.	- Establish agreements with CHEMS agencies. - Develop toolkit for CHEMS agencies for internal and external stakeholder engagement. - CHEMS agencies engage stakeholders.	12/15/2016 through 1/31/2018	IDHW $52,500
Increase the number of CHWs in Idaho.	CHW training.	- Recruit, enroll, and train CHWs. - Track and monitor training.	10/3/2016 through 12/29/2017	Idaho State University, IDHW $103,978

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Milestone/Measure of Success	Budget Activity	Action Steps necessary to complete activity (HOW)	Timeline (expected date of implementation)	Expenditures and Responsible Party (e.g., State, vendor, etc.)
	Provide technical assistance to SHIP clinics designated as Virtual PCMHs in the use of CHWs.	- Explore options for continuing education. - Determine approach. - Implement approach.	7/5/2017 through 8/15/2017	IDHW $45,000
Build telehealth capacity	Provide technical assistance to SHIP cohort clinics in incorporating telehealth in their clinic.	- PCMH telehealth program grant application period. - Application review period. - Secure funding from CMMI. - Distribute PCMH telehealth grants. - Begin monitoring and managing awarded PCMH telehealth grants.	12/13/2016 through 6/6/2017	IDHW, SHIP clinics $84,713 technical assistance for telehealth $212,782 for telehealth equipment $38,432 IDHW, Mercer, State Evaluation Team
	Provide funding to CHEMS agencies to implement CHEMS telehealth.	- CHEMS telehealth program grant application period. - Application review period. - Secure funding from CMMI. - Distribute CHEMS telehealth grants. - Begin monitoring and managing awarded CHEMS telehealth grants.	5/15/2017 through 9/25/2017	IDHW $52,500

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C.5. Goal 5

Milestone/Measure of Success	Budget Activity	Action Steps necessary to complete activity (HOW)	Timeline (expected date of implementation)	Expenditures and Responsible Party (e.g., State, vendor, etc.)
End user training.	Conduct training for end users including training for Cohort Two clinics and additional training for Cohort One clinics for new CQMs (5–10).	- Develop materials. - Review materials. - Provide training.	2/1/2017 through 1/31/2018	Health Tech $490,399
Operationalize data reporting on AY3 CQMs.	SHIP Cohort Two clinics will begin required reporting on the first four measures and optional reporting on the second group of six measures. SHIP Cohort One clinics will begin required reporting on measures 5–10.	- Clinics submit data through IHDE. - Support SHIP Cohort One and Two clinics in attaining full data reporting by helping identify missing data points from clinics needed for CQM reporting. - Assist clinics in working through data quality improvements.	2/1/2017 through 1/31/2018	Cohort clinics, IDHW, IHDE, HTS, KMP $490,399
Operationalize AY3 and AY4 CQMs.	Operationalize AY3 and AY4 measures and establish reporting pathway for claims-based measures.	- Identify alignment with other national initiatives such as MACRA. - Continue definition of measures to operationalize data reporting. - For claims-based measures, complete review of feasibility study for obtaining multi-payer claims data. - Based on results of feasibility study, establish connections with the payers and analytics.	2/1/2017 through 1/31/2018	HTS, IDHW, cohort clinics, KMP $200,000

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Milestone/Measure of Success	Budget Activity	Action Steps necessary to complete activity (HOW)	Timeline (expected date of implementation)	Expenditures and Responsible Party (e.g., State, vendor, etc.)
Define baselines for the initial four CQMs.	Set the baseline that will be used to measure future progress.	- Draft baseline report for each clinic. - Clinic reviews for reasonableness. - Analyze and resolve issues. - HTS sets the baseline.	12/1/2016 through 1/1/2018	HTS, IDHW, cohort clinics, KMP $490,399
Distribute CQM reports and data analytics feedback.	Provide reports and technical assistance.	- Provide data reports. - Provide data analytics feedback at the county and regional level. - Provide data analytics feedback at the State level. - Develop payer view of the data analytics dashboard.	2/1/2017 through 1/31/2018	HTS $490,399
Data analytics sustainability.	Development of sustainability plan for data analytics.	- Determine next steps for engaging funding sources. - Implement next steps as appropriate.	2/1/2017 through 1/31/2018	HTS, IDHW, Invoked Health $200,000

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C.6. Goal 6

Milestone/Measure of Success	Budget Activity	Action Steps necessary to complete activity (HOW)	Timeline (expected date of implementation)	Expenditures and Responsible Party (e.g., State, vendor, etc.)
Count of payers participating in non-FFS payment contracts.	Count of payers and collection of methods used by each payer to determine if they are using non-FFS payment methods.	Report the number of payers participating in non-FFS that link payment to value.	7/31/2017	$97,128
Track and report percentage of beneficiaries attributed to providers for purposes of alternative reimbursement payments.	Complete payer reporting template.	Payer reporting template completed and submitted to Mercer.	7/31/2017	Payers, Mercer, IDHW $97,128
Track and report percent of payments made in non-FFS arrangements.	Complete payer reporting template.	Payer reporting template completed and submitted to Mercer.	7/31/2017	Payers, Mercer, IDHW $97,128

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C.7. Goal 7

Milestone/Measure of Success	Budget Activity	Action Steps necessary to complete activity (HOW)	Timeline (expected date of implementation)	Expenditures and Responsible Party (e.g., State, vendor, etc.)
Track cost of care of population.	Pull data and report to Mercer.	- IDHW/Mercer requests data from payers. - Payers report data. - Mercer performs analysis of data. - Data reported to the IHC.	2/1/2017 for AY2 reporting and TBD for AY3 reporting.	Payers, IDHW, Mercer, IHC $291,654

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D. Program Monitoring and State-led Evaluation

D.1. State-led Evaluation

During AY2, IDHW contracted with the University of Idaho to serve as Idaho's State Evaluator. The University of Idaho partnered with Boise State University (collectively, the University Evaluation Team). In AY2, the University Evaluation Team prepared Idaho's state evaluation design and launched key evaluation activities (described in further detail below). IDHW shared the evaluation design with CMMI in September 2016.

The state evaluation will support Idaho's Model Test by providing continuous statewide modeling and analysis of process and outcome measures. The results of this analysis will enable rapid cycle evaluation by helping IDHW identify points of inefficiencies and timely corrections to improve implementation of the Model. State evaluation activities will be conducted in coordination with federal evaluation activities, described in the next section, and will not supplant or duplicate these activities.

The design of the state evaluation is centered on assessing the impact of the Model Test's core tenets related to PCMHs and Virtual PCMHs, the RC and Medical-Health Neighborhood, HIT, and payment reform. The state evaluation will capture perspectives and reactions of populations impacted by the Model Test, starting with patients. At the center of the evaluation is documentation of the patient's experience through brief surveys and focus groups. The clinical and clinic administrative staff who work in the PCMHs are the next focus of the state evaluation. The perspective and experience of these individuals will also be captured with brief surveys and focus groups. Lastly, a broad system-level perspective on the SHIP implementation process and results will be obtained through surveys and interviews with state-level stakeholders, IDHW, commercial insurers, and Medicaid administrators.

Research Questions and Logic Model

State evaluation activities are designed to answer the following research questions:

Table 14 – State Evaluation Research Questions

Goal	Research Questions
Goal 1	1. What patient-centered elements of the PCMH are selected by Idaho PCPs as the elements most promising for keeping patients healthy and for stabilizing patients with chronic diseases? 2. Which population health issues identified by Idaho stakeholders are selected by Idaho PCPs as the issues most important to address through a PCMH for maintenance of patient health? 3. What chronic health issues identified by Idaho stakeholders are selected by Idaho PCPs as the chronic diseases most important to address through a PCMH for stabilization of chronic disease? If a clinic does not have at least one of these chronic health conditions as a priority for their PCMH, what health issues are being addressed? 4. What changes in patient activation and self-care measures occur over time for patients enrolled in a PCMH according to chronic disease status? If technically possible, self-care measures will be linked with clinical outcomes.
Goal 2	1. What level of user satisfaction is observed by users of EHR and of the IHDE according to history with EHRs and the IHDE?
Goal 3	1. How do the PCPs participating in SHIP perceive the utility of the RC in supporting the PCMHs and the community's Medical-Health Neighborhood?

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Goal	Research Questions
	2. How do patients participating in their PCMH perceive the utility of the PCMHs and the community's medical neighborhood? Is improving referrals for necessary services? What do they find most and least useful in managing their care?
Goal 4	1. How many elements of the Virtual PCMH (CHWs, CHEMs, and telehealth services) are implemented through SHIP according to each District? 2. How do the PCPs participating in SHIP perceive the utility of the Virtual PCMH? 3. How do the patients participating in SHIP perceive the utility of the Virtual PCMH?
Goal 5	1. How do the PCPs participating in SHIP perceive the utility of the statewide data analytics system? 2. How do the RCs and IDHW perceive the utility of the statewide data analytics system?
Goal 6	1. What is the nature of the collaboration between the participating commercial insurers with regards to agreed-upon payment mechanisms for improved health outcomes: a. How are the managers in the PCMHs using these performance measures? How do the performance measures guide the managers in making operational decisions? b. What are some of the process improvements that have been implemented to increase patient care as well as reduce patient care cost as a result of review of the business process analytics? What are the providers' and patients' perspectives on these changes?
Goal 7	1. What are the barriers and facilitator factors for the providers achieving the projected financial saving goals? 2. What will be the most effective attributes in the SIM Model Test that help providers and payers in quality improvement, cost containment, and organizational competitiveness?

The University Evaluation Team has developed a corresponding data collection and analysis plan to support each question. Additional detail regarding these plans can be found in Idaho's State Evaluation Design, submitted to CMMI in September 2016. The state evaluation plan also describes the process and outcome measures that will be used and how they align with the quarterly and annual measures that IDHW will submit to CMMI as part of its SHIP reporting.

The University Evaluation Team has also developed logic models according to the seven goals of the Model Test that describe the scope of evaluation activities. These logic models can be found in Appendix C.

AY2 State Evaluation Activities

During AY2, the University Evaluation Team collaborated with IDHW to prepare for state evaluation activities. This included finalizing the state evaluation design and preparing for the first round of data collection with Cohort One clinics. Efforts focused on developing a patient survey, questions for patient focus groups, and interviews with clinic managers.

After preparations were finalized, the University Evaluation Team conducted a baseline test of the evaluation measures with a pilot of one SHIP cohort clinic. Based on results of the pilot, the full data collection process was implemented cohort-wide. Patient focus groups and interviews with clinic managers were conducted to collect baseline information. Transcripts of these activities were analyzed to produce data for the research questions listed above for Goals 1 through 4.

During this period, the University Evaluation Team produced quarterly reports to IDHW to enable rapid cycle evaluations and improvements in the Model Test implementation.

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Plans for AY3 State Evaluation Activities

Data collection and analysis related to the state evaluation will continue and expand in AY3. Drawing on lessons learned from the state evaluation with Cohort One, the University Evaluation Team will work with IDHW to plan for the second wave of data collection in AY3. Using the processes described in the State Evaluation Design, the University Evaluation Team will implement data collection with Cohort Two clinics for the research questions associated with Goals 1–4. Focus groups, surveys, and clinic staff interviews will be used again. All Cohort One clinics will be interviewed between January and March, 2017. A provider satisfaction survey will also be conducted. Data collection and analysis will also continue for the Goal 6 evaluation.

As in AY2, the University Evaluation Team will submit quarterly reports to IDHW and will work with IDHW to perform rapid-cycle evaluations to improve model performance.

Additional detail related to specific evaluation activities that will be performed in AY3 can be found in Idaho's State Evaluation Design.

D.2. Federal Evaluation, Data Collection, and Sharing

As stated in Idaho's AY2 Operational Plan, IDHW is committed to working with CMMI and the Federal Evaluator to support evaluation of Idaho's Model Test. In May 2016, IDHW worked with CMMI and the Federal Evaluator to facilitate a series of focus groups with providers and beneficiaries. This support and collaboration will continue in AY3. IDHW expects that its activities will include, but not be limited to, provision of qualitative and quantitative data as requested, participation in monthly evaluation calls, facilitation of site visits, focus groups, key informant interviews, and provision of reports, and additional deliverables as requested.

In AY2, CMMI and the Federal Evaluator developed research questions and an evaluation plan specific to Idaho's model. In AY3, IDHW anticipates continuing to work with CMMI and the Federal Evaluator to further refine and implement evaluation activities, including the timing and formatting of shared data. IDHW is committed to collecting, securing, and providing data, including file specification, in a manner determined by CMMI and the Federal Evaluator. To further support these efforts, IDHW is exploring the possibility of creating an identifier for all patients affected by Idaho's Model Test, regardless of payer.

IDHW is committed to working with CMMI to meet the objectives of the SIM evaluation in an ethical and appropriate manner. Regarding the provision of identifying contact information for beneficiaries who receive services under Idaho's SHIP, Idaho will work with CMMI up-front to create a process that meets CMMI's needs, is HIPAA-compliant, and respects the privacy of Idahoans. Where needed and appropriate, IDHW will work with CMMI to coordinate and facilitate data collection on behalf of CMS.

IDHW also anticipates cooperating with CMMI and the Federal Evaluator in the collection of quantitative and qualitative information regarding the Model Test implementation. This includes, but is not limited to, surveys, focus groups, and key informant interviews. IDHW will work directly with CMMI and the Federal Evaluator on these requests to ensure a smooth and efficient process and, wherever possible, to prevent duplicative efforts between state and federal evaluation activities. IDHW SHIP staff will continue to be the primary point of contact for these and all other data requests.

IDHW will ensure that the necessary legal mechanisms, authorities, and/or agreements are in place to ensure timely delivery of data to CMS and/or CMS contractors. If potential barriers to data delivery

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arise, IDHW will work with its local and federal partners to overcome these barriers. During the SIM design phase, stakeholders rejected the idea of changes to the law impacting payer data collection and reporting. Stakeholders were clear in stating that mandates and penalties do not work in Idaho, but that real change could occur through cooperation. Therefore, no mandate for data collection has been issued. Instead, payer data collection and reporting is being coordinated through the Multi-Payer Workgroup.

IDHW understands the importance of the SIM evaluation at the federal level and will coordinate with the Federal Evaluator and CMMI for any other needs/requirements to support the evaluation. IDHW agrees to not receive additional reimbursement for providing data or other reasonable information to CMS or any other government entity or contractor.

D.3. Program Monitoring and Reporting

Idaho's approach to project management emphasizes frequent and timely communication among project areas and regular tracking and reporting of project developments. Each of the seven SHIP goals has an assigned IDHW project manager who is responsible for monitoring the work and contractors associated with their SHIP goal. A team member from Mercer is also assigned to each SHIP goal to support the IDHW project manager. IDHW project managers meet weekly with contractors and with Mercer to discuss the status of activities, including schedule, risks, and outcomes. Contractors also submit status reports at regular intervals and update work plans.

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Figure 112 – Project Management Structure

In addition to the project management teams assigned to each SHIP goal, IDHW has also assigned leads for operations and grant/contract management who oversee all SHIP operations, grant management, and the state-led evaluation of the Model Test.

The project management teams and other leads are all responsible for working to align activities with other local, state, and federal initiatives, and for engaging SHIP's multiple external stakeholders in continued implementation of the model.

Rapid-cycle evaluation of project management and operations efforts is conducted on a regular basis. IDHW collects project information from different work streams and discusses progress and project direction weekly, making adjustments as needed to keep the project on track. This includes any changes to contract monitoring, such as the need for more frequent communication with contractors or, any issue-specific corrective action plans. While these operational rapid-cycle evaluations occur weekly, IDHW and the IHC also continually monitor the overall progression of the model, including the achievement of key milestones in each goal, and also more broadly, how each goal is fitting together and contributing to progress in reaching the other goals.

IDHW and Mercer work together to monitor and manage risks. Risks are captured in a risk log and, depending on the probability and impact of each risk, mitigation strategies and contingency plans are developed and activated. IDHW and Mercer project managers discuss and frequently update the risk log.

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IDHW submits the risk log and discusses it with CMMI on a monthly basis. In AY3, IDHW will continue the established risk management process. For additional information on risks, please refer to the risk log in Appendix B.

In AY3, IDHW will continue its implementation of the Model Test with an eye toward the sustainability of program operations beyond the SHIP funding period. Section E of this Operational Plan describes Idaho's sustainability plan, including the long-term strategy for continuing Idaho's health system transformation.

D.4. Fraud and Abuse Prevention, Detection, and Correction

In AY3, fraud and abuse prevention, detection, and correction will continue to be a focus of Idaho's Model Test in two main areas: payment transformation at the payer level; and distribution and tracking of reimbursement payments for PCMH transformation, Virtual PCMH, and telehealth.

As individual payers participating in the Model Test continue to move their payment methodologies toward value-based payment, each payer will implement appropriate fraud and abuse prevention, detection, and correction activities. Payers will continue to have the flexibility to implement fraud and abuse activities as they consider appropriate.

IDHW's financial support of clinic-level transformation will continue in AY3 with the distribution of PCMH and Virtual PCMH reimbursement payments to next year's cohort clinics. Briljent and Myers and Stauffer will continue to implement the fraud and abuse prevention activities related to the payments that were launched in AY2. The Myers and Stauffer team will again use IPAS to distribute payments to qualifying clinics. The Myers and Stauffer team will implement program controls to ensure the right payments are distributed to qualifying clinics in a timely manner. They will also be responsible for identifying issues or potential red flags related to the payments. Clinics that do not comply with minimum requirements for participation in PCMH technical assistance and support activities will be required to return the PCMH transformation reimbursement payment.

At this time, IDHW has not identified any fraud and abuse protections that pose barriers to implementing the Model Test in AY3. Should any barriers be identified prior to or during AY3, IDHW will work with our federal partners to obtain necessary waivers from the Office of the Inspector General and CMS.

The Legislative Audits Division of the Legislative Services Office has identified SHIP and the Office of Healthcare Policy Initiatives to be part of their annual single audit. The process commenced in October 2016 and will conclude in March 2017 with an analysis and presentation of findings to IDHW and the legislature.

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E. Sustainability Plan

Changing a statewide multi-payer health system requires an investment of significant financial and human resources. Since deciding to embark on this journey of healthcare transformation, Idaho has always been mindful of the need to sustain both the momentum gained and the changes that will have occurred by the end of the grant period. Idaho applied for SHIP grant funding knowing that this was potentially a one-time opportunity to garner financial support for transformation given that the state does not have the resources to replace federal dollars when the grant ends.

With that in mind, Idaho chose to invest their grant funds primarily in establishing and expanding the foundation upon which transformative change will occur. For example, the upfront costs to develop HIT and data analytics infrastructure that are occurring now will provide a future platform for data analytics and reporting at an affordable cost to the state in future years. The investment in a regional infrastructure to support PCMH transformation and population health will be sustained beyond the grant period due to the grant seed funds supporting new partnerships between healthcare providers, stakeholders, and the PHDs. The commitment and collaboration across payers to advance value-based payment models will help sustain improved healthcare delivery into the future.

While Idaho has invested its grant funds to build a foundation that will support sustainment of the delivery system and payment models, the state understands that, realistically, some funding will be needed to continue and maintain implementation of the model. Effective February 1, 2016, IDHW is restructuring the Healthy Connections and Health Home Programs to incentivize primary care providers to expand to the PCMH model of care. More information can be found at: http://healthandwelfare.idaho.gov/Default.aspx?TabId=216. This program change is advancing payment structure and encouraging implementation of the PCMH model in Idaho.

Idaho continually looks for opportunities to participate in federal funding opportunities to expand innovation and best practices across the state's health care system. For example, three Idaho FQHCs are participating in the FQHC Advanced Primary Care Practice Demonstration and providers across the state participate in the Million Hearts: Cardiovascular Disease Risk Reduction Models. In 2016, payers considered applying for the Comprehensive Primary Care Plus (CPC+) program but, for a variety of individual reasons, decided not to pursue it at this time. Idaho's Medicaid program did apply for CPC+ but their application was not selected. The MACRA rule and Quality Payment Program were just finalized and Idaho will be evaluating how to support practices in the implementation of their programs. Support may include providing technical assistance to practices and incorporating components of this into individual SHIP cohort clinic transformation plans.

The Idaho Division of Public Health and the seven PHDs will play critical roles in the sustainability of Idaho's long-term funding and support for population health improvement activities. Idaho Public Health's mission focuses on improving population health by 1) preventing disease, disability, and premature death; 2) promoting healthy lifestyles; and 3) protecting the health and quality of the environment. The goal of SHIP to implement and expand delivery system and payment models to improve population health is a natural fit with the mission of public health. Long before the SIM Test grant was awarded to Idaho, the PHDs were working to improve population health and their work in this area will continue after the grant period ends. Each district's RC is supported by its PHD and has been tasked with developing a sustainability plan that includes addressing financial stability. Each RC's financial sustainability plan may include leveraging a variety of financial resources.

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In AY3, the Office of Healthcare Policy Initiatives and the IHC will continue to make sure the model is implemented in a sustainable way and will continue efforts to identify future funding for transformation activities, and that CMMI and the ONC will be important partners in this work.

Sustaining the HIT Components of Idaho's Model

Idaho has developed a specific sustainability strategy for the HIT components of the model, so that HIT can continue to enable healthcare system transformation after the Model Test period concludes.

The statewide HIT Plan, currently in development, will unify Idaho's multiple HIT efforts under a common direction aimed at achieving statewide HIT targets. At the discretion of the Governor, HIT leadership, and data governance in Idaho will continue under the direction of the IHC and its workgroups. Idaho recognizes the importance of payer participation in data governance, and will continue to seek payer representation in data governance groups.

Provider connections to IHDE are also expected to continue after the Model Test period. In AY3, Idaho will continue to identify alternative sources of funding to support these connections moving forward. Presently, as mentioned in Section B.4, HITECH dollars are anticipated to be an important source of financial support for the IHDE and subcontractor cost component of IHDE connection fees. The IDHW SHIP team is also working with Medicaid on an advanced planning document that describes plans to use Medicaid funds to support connection costs of clinics, hospitals and Medical-Health Neighborhood participants to IHDE.

Creating a sustainability plan for the data analytics infrastructure will be a critical area of focus in AY3 and AY4. The first step in defining a sustainability plan is to fully implement data analytics as described in Section B.4 in order to demonstrate a working system and prove the added value that analytics bring. At that point, IDHW will engage potential funding sources regarding support for data analytics moving forward.

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Appendix A: SHIP Metrics

LINK TO DOCUMENT:
http://ship.idaho.gov/Portals/93/Documents/SIM%20Data%20Reporting/IDSIM%20Metrics%20Q3AY2%20V1.0F.xlsx?ver=2016-11-30-092028-607

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Appendix B: Risk Assessment and Mitigation Strategies

Risk ID	Description & Goals Impacted	Risk Probability	Risk Impact	Dependency ID	Current Strategy/Steps	Timeline
22	HIT Connections: Statewide HIT connections not in place by selected deadlines. **Goal 2**	High	High	None	HTS's approach to complete reporting requirements with data available. Plan on establishing connections as soon as possible, into next grant year. Apply lessons learned to next cohort and leverage connection efficiencies to get back on schedule.	Continuing to monitor through the IHDE reports and keeping HTS up to date. Keeping CMMI apprised of progress and proposed timelines.
29	CHW model adoption by PCMH: There is limited CHW model adoption by PCMHs because CHWs are not reimbursed. **Goal 4**	Medium	High	None	1. Engage the payers in a different way. 2. Increase outreach coordination with medical home collaborative and PHDs.	Utilize ongoing MPW forum and one-on-one meetings to address the issue.
35	Data Reporting: Problems with data cleansing and gap analysis. Identification of unanticipated technical obstacles may require increase in scope and or budget for IHDE and/or HTS. **Goal 5**	High	High	Risk ID 23	Document new scope changes and evaluate potential solutions, including decreasing scope or transferring funds from another part of the project. Utilize consultants to ensure best practices and efficiencies are applied wherever possible.	Currently pursuing HealthTech contract amendment to include the additional scope items.

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Risk ID	Description & Goals Impacted	Risk Probability	Risk Impact	Dependency ID	Current Strategy/Steps	Timeline
39	PCMH Participation: The temptation to "check the box" on becoming a PCMH could pose a threat to true transformation at the practice level. **Goal 1**	Low	High	None	NCQA also addressing this issue through 2017 standards. Briljent will implement a robust training effort paired with technical assistance to PCMHs. This includes interactive learning collaboratives, regional conferences, monthly coaching, and identification of champions.	Individualized training and TA from HMA coaches is taking place to overcome these barriers. Medicaid's current tiered payment model (Healthy Connections) encourages practices to truly transform in order to receive higher Medicaid case management payments.
40	PCMH Payments: Incorrect distribution of PCMH reimbursement payments: paying the wrong practice, incorrect reporting and accounting of federal funds, and delays in payments. **Goal 1**	Low	High	None	1. Develop policies and procedures for collecting timely, accurate information from providers, including a policy for providers. 2. Ensure that Briljent/Myers and Stauffer's implementation of the payments is consistent with IDHW expectations. 3. Establish policies and procedures for reporting information. 4. Require qualifying practices to sign an attestation as their agreement or acknowledgment that the practice is responsible for distributing funds among participating physicians. 5. Define the process for adjudicating potential issues to avoid the appearance of, or the risk of, making arbitrary decisions.	All strategies have been implemented and are monitored via contract monitoring and on weekly project management calls with Briljent.

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Risk ID	Description & Goals Impacted	Risk Probability	Risk Impact	Dependency ID	Current Strategy/Steps	Timeline
48	Capacity of RC Champions: RC Champions may have competing priorities and decreased capacity to meet expectations. **Goal 1 & 3**	Medium	High	None	1. Consulting internally to determine whether transition strategy can be added to RC strategic plans. Consult with Dr. Epperly. 2. Develop a transition strategy for use in the event that there are leadership changes.	Consultation is currently occurring and a transition strategy will be documented and adopted in early AY3.
51	Insufficient Staff Resource: Not enough human resources available to complete work necessary to implement Goal 4. **Goal 4**	High	High	None	1. Seek additional staff resources from SHIP. Update: Additional funds were not approved (Idaho appropriation) for additional staff resources. Undergraduate student assistant did not meet performance expectations.	As the new Goal 3/4 Project Manager is hired, the distribution of work between the two goals is being re-evaluated. Anticipated to be updated Jan 2017.
54	Claims Database Not Available: IHDE or HTS unable to create claims database. **Goal 2**	Medium	High	None	A study will be used to develop next steps. Identify alternative source for claim data and a place to aggregate them.	IHDE is scheduled to complete the claims feasibility study by the end of AY2 to determine what is possible.
61	Payers & Hospitals Connections Viability: Payers and Hospitals do not connect or remain connected to IHDE.	Medium	High	None	Support IHDE in their communication effort to hospital and payers in addressing and emphasizing the value IHDE provide.	IHDE has updated their pricing structure to make hospital connections more feasible for smaller and intermediate sized hospitals

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Risk ID	Description & Goals Impacted	Risk Probability	Risk Impact	Dependency ID	Current Strategy/Steps	Timeline
	Goal 2				Provide strategies to enhance IHDE value.	in addition to updating their marketing materials.
83	Lack of Resources to Address Data Gaps: Specific resources (SHIP team or contractors) have not been identified to work with clinics to help them address data gaps. This process is can be labor intensive. Long term impact can be if the data quality issues are not addressed, the SHIP analytics are not helpful and therefore over time less and less used. **Goals 1, 2, 3 & 5**	High	High	Risk ID 62	1. ONC TA Request to address this issue. 2. Update resource allocation to implement determined solution – may require scaling back deliverables. 3. Explore incentives to increase clinic participation and ownership.	TA request is currently being fulfilled and plan will be determined in Dec16/Jan17 to be implemented in AY3.
89	Goal 1 Contract Scope/Alignment: Misaligned language between the PHD and PCMH transformation contractor contracts re: scope and objectives of HMA coaches versus PHD SHIP staff in supporting SHIP clinic transformation. **Goals 1 & 3**	Low	High	None	Continue increased communication and coordination between Goal 1 and Goal 3 project managers as well as IDHW and the Office of Rural Health.	Meetings are occurring at least twice monthly between the necessary parties and will continue.

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Risk ID	Description & Goals Impacted	Risk Probability	Risk Impact	Dependency ID	Current Strategy/Steps	Timeline
26	CHEMS Engagement: Newly trained CHEMS professionals do not remain engaged with EMS agencies. **Goal 4**	Low	Low	None	1. Proactive coaching with EMS agencies when hiring candidates. 2. Address within MOU with EMS agencies.	In process of implementation with an anticipated completion date of March 2017.
55	Cohort 1 Build Continuing into AY3: While building initial cohort 2 connections, IHDE will also have to enhance cohort 1 connections to support year 2 measures. **Goal 2**	High	Low	None	1. Ensure activity is correctly accounted for in IHDE's Year 2 contract as well as HTS's work plan. 2. Support leveraging lessons learned and consolidation of work effort wherever possible.	Implemented and monitored via contract monitoring reports and weekly vendor call.
57	Connection to Regional HIE: IHDE unable to connect to regional database. **Goal 2**	Medium	Low	None	1. IHDE is scheduled to complete feasibility study by end of AY2 to determine what is possible. 2. Evaluate options and recommendations.	Feasibility study is due by the end of AY2
65	Data Mapping Timeline: Data mapping for year 2 and 3 takes longer than anticipated. **Goal 5**	Low	Low	None	1. Convene CQM/HIT Workgroups inform of challenges, seek recommendations from the WG for SHIP to implement.	Discussion of Y2 and Y3 measures at CQM/HIT meeting scheduled for 11/30.
67	EHR CQM Version Changes: The final CQMs might be different that the final MACRA / MIPS version. **Goal 5**	Low	Low	None	1. Convene CQM/HIT Workgroups inform of challenges, seek recommendations from the WG for SHIP to implement.	Discuss at the upcoming CQM/HIT meeting scheduled for 11/30

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Risk ID	Description & Goals Impacted	Risk Probability	Risk Impact	Dependency ID	Current Strategy/Steps	Timeline
68	Goal 6 Metrics: Count of provider contracts metric may not be meaningful and data may not be available. **Goal 6**	High	Low	None	Will discuss with payers at individual meetings about how to gather a meaningful metric.	Financial data collection and analysis is underway.
74	CHEMS Training Funds: Lack of CHEMS training funding, which is now being provided by EMS Bureau. **Goal 4**	Low	Low	None	Blend different program funds to address the gap.	Meet with SHIP leadership to move funding from one CHEMS initiative to another.
79	EHR Conversion: Clinics that may do an EHR conversion after the connection has built and that may impact the reporting numbers **Goals 2 & 5**	High	Low	None	Work with clinics to make sure EHR conversion does not result in any downtime or loss of data. IHDE track conversions and work with clinic to ensure seamless connection.	IHDE is currently tracking this status and reporting to SHIP.
85	Clinic Contracts with IHDE: Clinics are not willing to sign IHDE contracts. **Goals 2 & 5**	High	Medium	None	Address on a case-by-case basis pulling in other stakeholders as necessary to make the most persuasive case.	Monitoring and addressing the few issues as they arise on a case by case basis.
2	Data for Financial Analysis: Difficulty obtaining payer data for measuring progress compared to the financial analysis. **Goals 6 & 7**	High	Medium	None	Continue sending data requests and reminder notices to payer contacts. Use available public information such as NAIC filings to the extent possible to inform progress.	Financial data collection and analysis is underway. Medicare has committed to submitting data.

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Risk ID	Description & Goals Impacted	Risk Probability	Risk Impact	Dependency ID	Current Strategy/Steps	Timeline
6	Limited ability download guidance: IDHW/Mercer cannot access all resource materials on the CMMI collaboration website, which could impact the Operational Plan. **All Areas**	High	Medium	None	Follow-up on IDHW's help desk request to address this issue.	Ongoing contact with CMMI and routine communications have helped address the need for information; this risk remains ongoing.
7	Medicare Data: Timeliness of Medicare data may impede the initial financial analysis. **Goal 7**	Medium	Medium	Risk ID 3	Old data may be substituted and trended forward until more recent data is available.	Financial data collection and analysis is underway. Medicare has committed to submitting data.
8	Payer Data: Operational Plan requires data that may not be available from the payers. **Goal 6**	Medium	Medium	Risk ID 2	Use high-level data from NAIC filings.	Financial data collection and analysis is underway.
12	Metric Alignment: Conflicting guidance from CMMI regarding mandatory versus optional measures for federal reporting. **All Areas**	High	Medium	None	Will need to determine whether/how to reconcile Federal Core Metrics with existing Idaho metrics. Develop crosswalk and discuss approach with project officer.	A metric change request will be submitted to CMMI in AY3 (only AY3 & 4 metric amendments).

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Risk ID	Description & Goals Impacted	Risk Probability	Risk Impact	Dependency ID	Current Strategy/Steps	Timeline
14	Providers Following Protocol: Clinical and broader public/social health providers do not follow established protocols for referrals and follow-up communication with PCMHs. **Goals 1 & 3**	Medium	Medium	None	1.Goal 1 PM to discuss with Goal 3 PM. Participation of Medical-Health Neighborhood participants in development process of communication protocols. 2. Clear definition of Medical-Health Neighborhood and key participants. 3. Effective communication process for Medical-Health Neighborhood participants to raise concerns. 4. Begin collecting information about communication capabilities of potential Medical-Health Neighborhood participants. 5. Review lessons learned from IMHC and other states that have taken a similar approach to creating.	1. Consider adding role for Regional Collaboratives in the mitigation strategy. 2. PHW is addressing the MHN topic and mechanism, anticipated to have additional information for the IHC in early AY3.
15	Misaligned timelines and efforts: Misaligned timelines and duplicative efforts among Briljent, IHDE, and Data Analytics Contractor. **Goal 3**	Medium	Medium	None	1. Establish communication protocols for all contractors assisting with PCMH transformation, quality improvement, and data exchange efforts. 2. Contractor timing should be aligned. 3. Establish regular meetings for contractors to share information with one another.	Contracts for all AY3 contracts are being updated (e.g. scope, timelines, deliverables, etc.) and careful consideration of interaction is being respected.

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Risk ID	Description & Goals Impacted	Risk Probability	Risk Impact	Dependency ID	Current Strategy/Steps	Timeline
16	Risk arrangements: Enough beneficiaries fail to attribute to each provider for each payer, making risk arrangements unfeasible. **Goal 6**	Low	Medium	None	1. Could retire when data shows attribution and conversion to risk-based payment models, however, we should wait until membership is sufficiently attributed. 2. Lower minimum threshold for beneficiary attribution and institute risk corridors to minimize risk for both payer and providers.	Data collection and processing currently underdway.
17	SHIP Model implementation failure: Failure to implement the SHIP model. **Goal 7**	Medium	Medium	None	1. Allowing additional primary care based models in lieu of PCMH practices where payments still incent outcome over volume. 2. Engage IHC in discussion and planning of alternatives that can be operationalized. Each payer has a different strategy for implementation.	Ongoing monitoring and communication with MPW and IHC members.
23	Data sources unavailable: Anticipated data sources unavailable/inadequate to meet reporting needs. **Goal 2**	High	Medium	None	Minimize data gap through identification and prioritization of additional connections and/or workflow changes. Include quality rating of measures reported on dashboard that reflects potential issues due to data gaps.	Developing a data quality improvement process to assist clinics and will be deployed in AY3.
24	Data reporting: PCMHs lack resources to support data collection and reporting. **Goal 2**	Medium	Medium	None	1. Provide training and documentation on clinic workflow changes. 2. Include quality rating of measures reported on dashboard that reflects potential issues due to data gaps.	Developing a data quality improvement process to assist clinics and will be deployed in AY3.

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Risk ID	Description & Goals Impacted	Risk Probability	Risk Impact	Dependency ID	Current Strategy/Steps	Timeline
30	Student participation: Lack of student participation in training. **Goal 4**	Medium	Medium	None	1. Align with CHW outreach committee to assure appropriate information distribution to stakeholders and potential CHWs. 2. Broaden target and reach out to individuals.	The CHW recruitment video was released. Ongoing communication with key stakeholders continues.
31	HIT Contractors: Delay in IHDE contract negatively impacts key milestones and other entities ability to deliver on time. **Goal 5**	High	Medium	None	1. Possible mitigation strategies is to focus on a few clinics first for their CCDA connection and get the data flowing to HealthTech quicker. 2. Increase monitoring of IHDE's activities and schedule. Keeping stakeholders aware of the change to the timeline. 3. Identify any flexibility in schedule and adjust HTS' schedule/contract terms where possible.	Continue to monitor and keep track. Approximately 1/2 of clinics will not be connected by end of AY2. Additionally, HTS has modified the approach to implementation to minimize impact and maximize amount of reporting available.
36	Interest in PCMH transformation: Number of clinics participating in a SHIP cohort after year 1 and year 2 of the Model Test is lower than expected. **Goal 1**	Medium	Medium	None	1. Increase stakeholder education and recruitment activities to increase provider interest in becoming a PCMH. 2. Evaluate ways to increase support for PCMHs, including leveraging the PCMH mentoring program. 3. Conduct an evaluation of SHIP cohort 1 clinics to assess effectiveness of the transformation process and educational components.	1. Cohort 2 Clinics will be offered two tract choices: PCMH experienced or PCMH novice. 2. Continue coordinating with subcontractors to implement strategies.

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Risk ID	Description & Goals Impacted	Risk Probability	Risk Impact	Dependency ID	Current Strategy/Steps	Timeline
38	PCMH Model: Challenges at the practice level in shifting to a coordinated PCMH model. **Goal 1**	Medium	Medium	None	1. Identify PCMHs that achieved quick successes and created collaborations among the teams in the regions to celebrate initial successes and share "best practices." 2. Ensure timely communications between HMA, PHD staff and practices to enable effective practice-level technical assistance and support. 3. Eventually, new payment methodologies will help shift the culture of FFS to a model based on quality and outcomes on a broader scale.	1. Cohort 2 Clinics will be offered two tract choices: PCMH experienced or PCMH novice. 2. Continue coordinating with subcontractors to implement strategies.
42	PCMH Contractors: Multiple contractors and other state initiatives/programs requesting information could burden participating practices and threaten participation. **All areas**	High	Medium	None	Before requesting information from the practices, IDHW will evaluate whether the information is already being collected and will coordinate the information request.	Practice implemented. No updates.

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Risk ID	Description & Goals Impacted	Risk Probability	Risk Impact	Dependency ID	Current Strategy/Steps	Timeline
47	Briljent subcontractor monitoring: Ineffective management by Briljent of their subcontractors could negatively impact Goal 1 scope, communications, cost, or schedule. **Goal 1**	Low	Medium	None	1. Communication will be increased between IDHW and Briljent PM. Increased IDHW monitoring of Briljent contract to ensure scope and budget compliance. 2. IDHW will re-evaluate Briljent contract for AY2. 3. Briljent to implement a CAP to address identified project management and subcontractor management issues.	Briljent completed their CAP. IDHW will continue to monitor Briljent's management of subcontractors.
49	Insufficient training for SHIP PHDs: Insufficient training opportunities for PHD staff as currently available. **Goal 3**	Low	Medium	PCMH transformation, PCMH contractor	1. Submit request for additional resources and or funds. 2. Identify training opportunities for staff. 3. Secure resources for training.	Assistance was obtained through CMMI and the process for obtaining TA for PHD SHIP staff.
50	RCs do not have information needed: RCs do not have the information needed to assess quality and performance in their region. **Goal 3**	High	Medium	IHDE, HTS	Identify different sources of data (e.g. Public Health Division, Public Health Districts, clinics). RCs are the consumers of the information and will synthesize information from various sources and report once a year.	Alternate data sources have been communicated to RCs.

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Risk ID	Description & Goals Impacted	Risk Probability	Risk Impact	Dependency ID	Current Strategy/Steps	Timeline
52	EMR Challenges: The variety of EMRs and the level of effort to manage different specifications, report on CQMs and complete builds is potentially underestimated. Additional EMR concerns includes unanticipated EMR conversions resulting in delays, EMR barriers resulting in inability to produce required measure data and additional cost of multiple requests to map additional data fields. **Goal 2**	High	Medium	None	1. Track EMRs types and document capabilities and issues. 2. Use information for future Cohort connection planning. 3. Schedule connection builds based on knowledge of EMRs to minimize duplication of effort.	Developing solutions on a case by case basis.
56	IHDE cannot connect to hospitals: IHDE unable to meet target for hospital connections. **Goal 2**	Low	Medium	None	Encouraging IHDE to pursue and continuing to track but not within SHIP project funding.	Ongoing monitoring via weekly meetings.
59	Nonstandard measures proposed: CQM Workgroup or BHI Workgroup support a measure in year 2 or 3 that does not align with a national measure. **Goal 5**	Low	Medium	None	BHI Workgroup to take on topic.	Will be addressed in AY3 if required. Pending outcome of Nov 30 CQM/HIT Workgroup meeting.

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Risk ID	Description & Goals Impacted	Risk Probability	Risk Impact	Dependency ID	Current Strategy/Steps	Timeline
60	Financial support for EMRs/connections: lack of clarity regarding the clinic's financial responsibility related to IHDE connections (i.e. EMR's annual maintenance fee) continuing to pay for the IHDE view licenses in following years. Also, provider issues developed due to difference with financial support for IHDE connections. **Goal 2**	High	Medium		1. Review existing communication on this issue and modify to add clarity. 2. Enhance MOU language for next cohorts. 3. Clinics sign EMR maintenance fee agreement with IHDE; engage IHC chairman to discuss with clinics that have expressed concerns; point to potential Medicaid cost benefits for connecting.	In AY3 planning on leveraging Medicaid HITECH funds to offset some of the connection costs. Cohort Two communications package being developed in December 2016.
62	Clinics' CQM/EMRs knowledge gap: Clinics lack sufficient knowledge of CQM/EMRs to support the reporting of CQMs. Goal 2	Medium	Medium	None	1. Leverage EMR affinity groups. Leverage clinic EMR relationships to provide training where there may be gaps. 2. Leverage consultant's knowledge to assist in putting together communication material for clinics. 3. Incorporate CQM/EMR information into clinic communication and training.	1. Discuss issue with CQM/HIT Workgroup to address specific training with all contractors to clarify roles and responsibilities.
63	Clinic expectation of initial CQM report: Clinics' expectations of initial CQM reports are not met due to unresolved data gaps.	High	Medium	None	1. Developing a gap analysis template that includes a note section to provide additional information on how to address gaps and interpret reports provided.	Continues communications to ensure expectations are aligned with current status of reports.

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Risk ID	Description & Goals Impacted	Risk Probability	Risk Impact	Dependency ID	Current Strategy/Steps	Timeline
	Goal 5				2. Address expectations in advance, during and after the data analytics training the clinics receive.	
66	Cohort 2/3 lack EMRs and IHDE connection ability: Cohort 2/3 clinics don't have EMRs or can't connect to IHDE. **Goal 2**	Low	Medium	None	1. Continuing to track Cohort application responses. 2. Evaluate the need ongoing to adjust if an accommodation were required.	Cohort Two selection is underway and will be announced December 2016.
80	Budget issues due to cost increases: We will not have enough in the budget to connect all Cohort 1 clinics this year. Cost of HealthTech contract amendment exceeds available funds. **Goals 2 and 5**	High	Medium	None	1. Continue building connections for Cohort One clinics into AY3. Leveraging efficiencies with Cohort Two clinics already connected and have a reduced costs for these connections. 2. Coordinate with Medicaid for access to HITCH funds. 3. Structure the HTS budget for the amendment to include hourly rate and cap representing only portion of cost increase and closely monitor progress against costs.	1. Cohort build schedule has been updated to reflect changes. 2. Ongoing conversation are taking place with Medicaid, a draft APD is being circulated. 3. HTS Contract amendment is underway.
84	IHDE Leadership: IHDE no longer has an Executive Director; organization is going through a transition and reboot.	High	Medium	None	1. SHIP remain to remain in close contact with Dr. Turner (IHDE Board Chairman)	It may be several months before the Board determines the leadership needs as several strategic options exist for the

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Risk ID	Description & Goals Impacted	Risk Probability	Risk Impact	Dependency ID	Current Strategy/Steps	Timeline
	All areas				2. Participate in weekly update meetings as the situation is addressed. 3. Maintain contract monitoring activities with vendor.	organization. Utilizing the weekly meetings, SHIP will remain up to date on changes.
86	SHIP Budget: Costs for certain goal activities and contracts are increasing and need to establish those budgetary increases as risks on the risk log. **All areas**	Medium	Medium	None	1. Complete an annual budget scope analysis for all goal areas of the project. Ensure alignment, scope creep, budget limits are all clearly mapped and understood 2. Provide findings to executive leadership team as decision support tool.	Analysis will be completed in January 2016 for presentation in February 2017.

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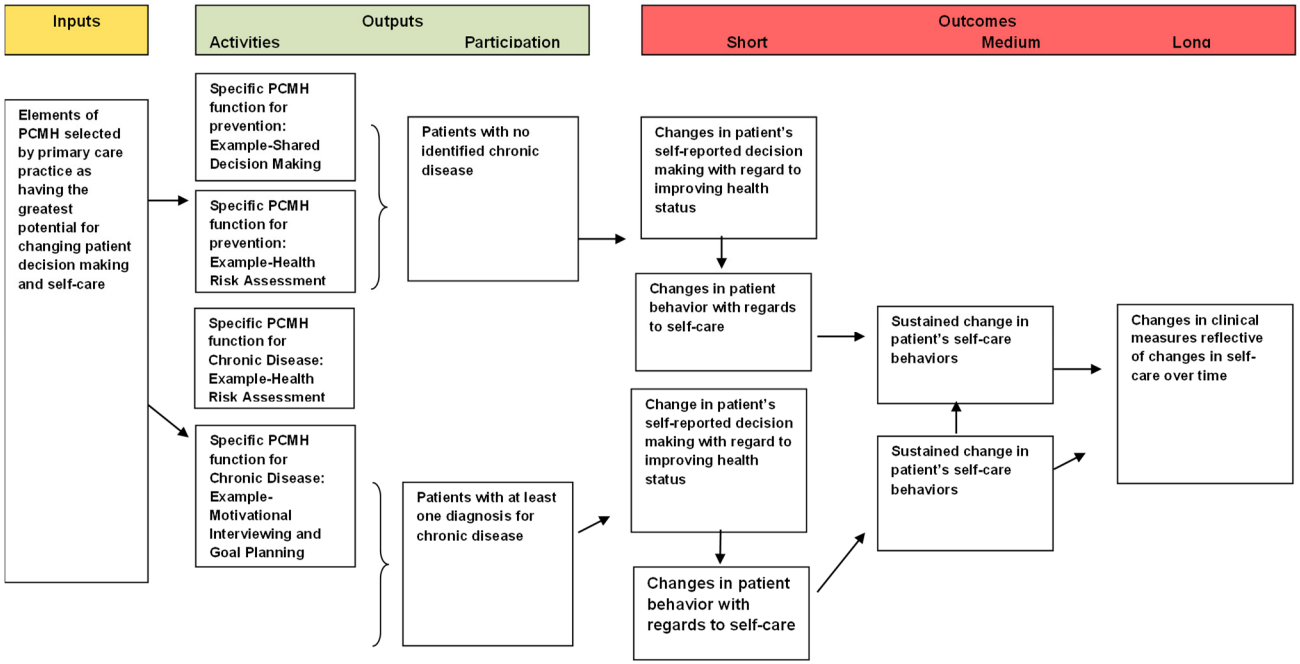
Appendix C: State Evaluation Logic Models

Figure 12 – Logic Model for Goal 1[23]



[23] Assumptions: 1) Primary care practices will be able to identify specific elements from the PCMH model with the potential to change patient behavior and health status. 2) Patients will be willing to attempt some aspect of change in their decision making and self-care behavior. 3) Patients will agree to participate in short semi-structured interviews about their PCMH experience. 4) Patients with at least one chronic disease will be more difficult to contact and engage in their PCMH. 5) Primary care practices will be able to identify patients who are in at least the contemplation phase of stage of change. External Factors: 1) Clinic is unable to fully implement PCMH element because of competing factors for clinician time and effort. 2) Changes in patient health and/or insurance status which interfere with participation in the PCMH.

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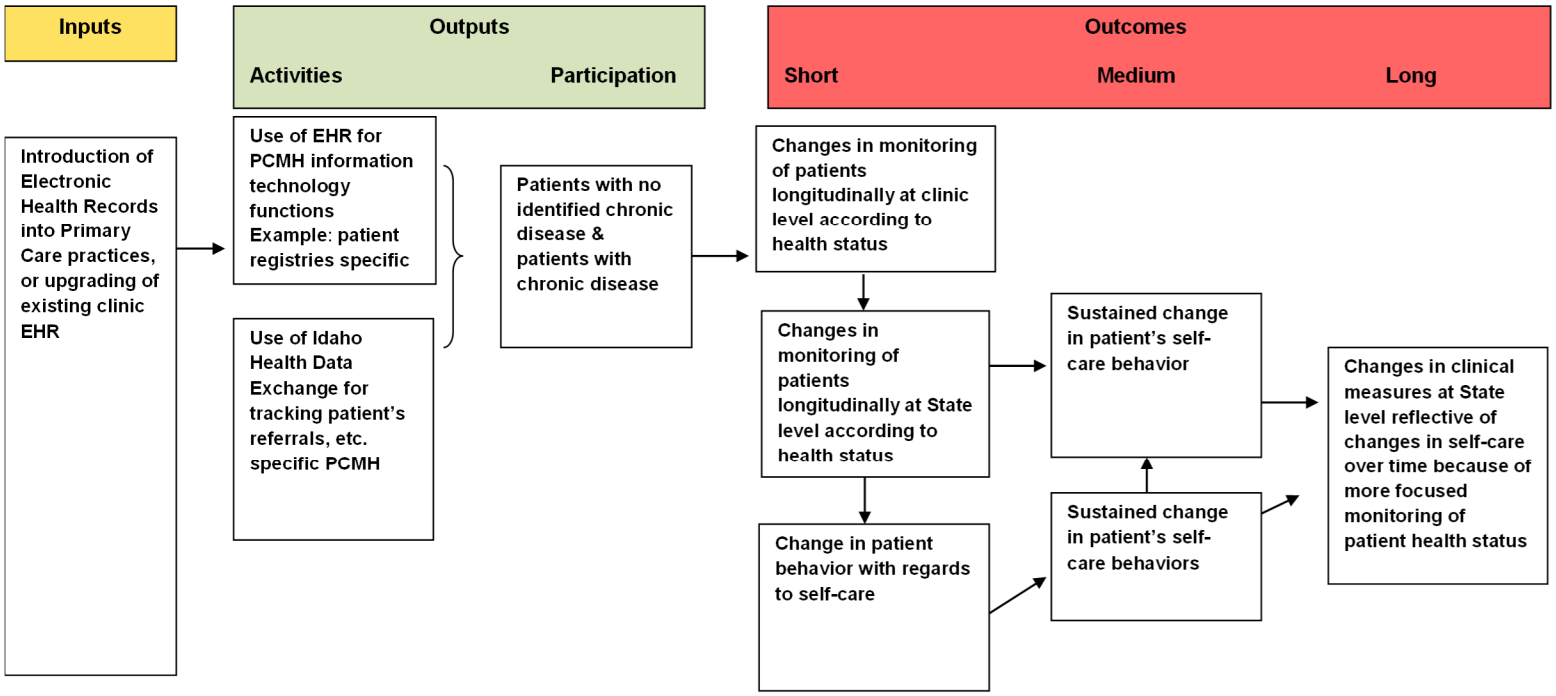
Figure 14 – Logic Model for Goals 2 and 5[24]



[24] Assumption: 1) Primary care practices will be able to effectively use EHR. 2) Primary care practices will be able to effectively use IHDE. External Factors: 1) Clinic is unable to fully implement EHR because of competing factors for clinician time and effort. 2) Clinic is unable to fully implement EHR because of clinician dissatisfaction with software.

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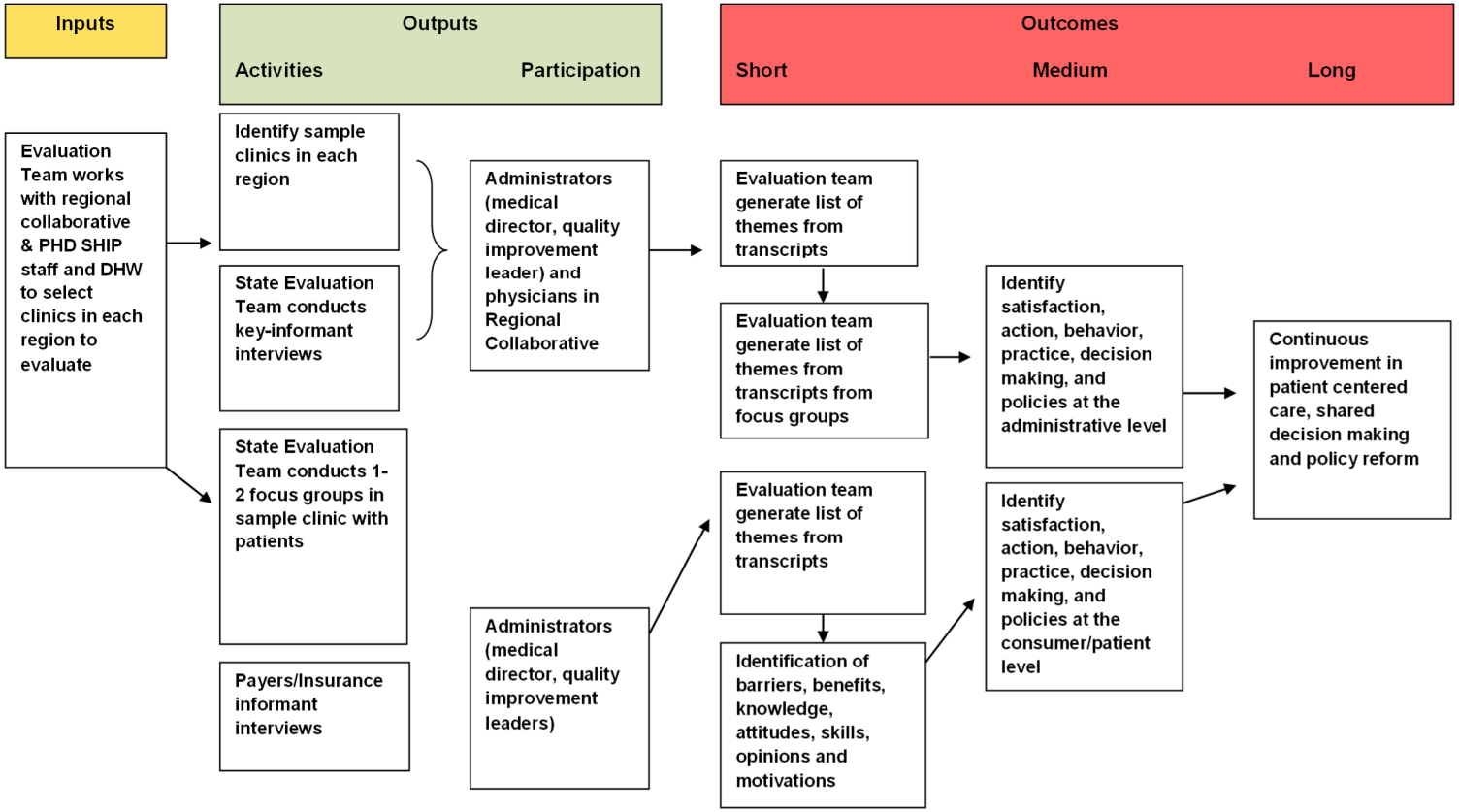
Figure 13 – Logic Model for Goal 3[25]



[25] Assumptions: 1) Administrator's willingness and time to participate in 60-minute interviews. 2) Patients will be willing to participate in 60-90 minute focus groups. 3) Standardized question use for interviews and focus groups. External Factors: 1) Clinic is unable to fully implement PCMH element because of competing factors for clinician time and effort. 2) Changes in patient health and/or insurance status which interfere with participation in the PCMH. 3) EHR connectivity potential is in place at selected clinics.

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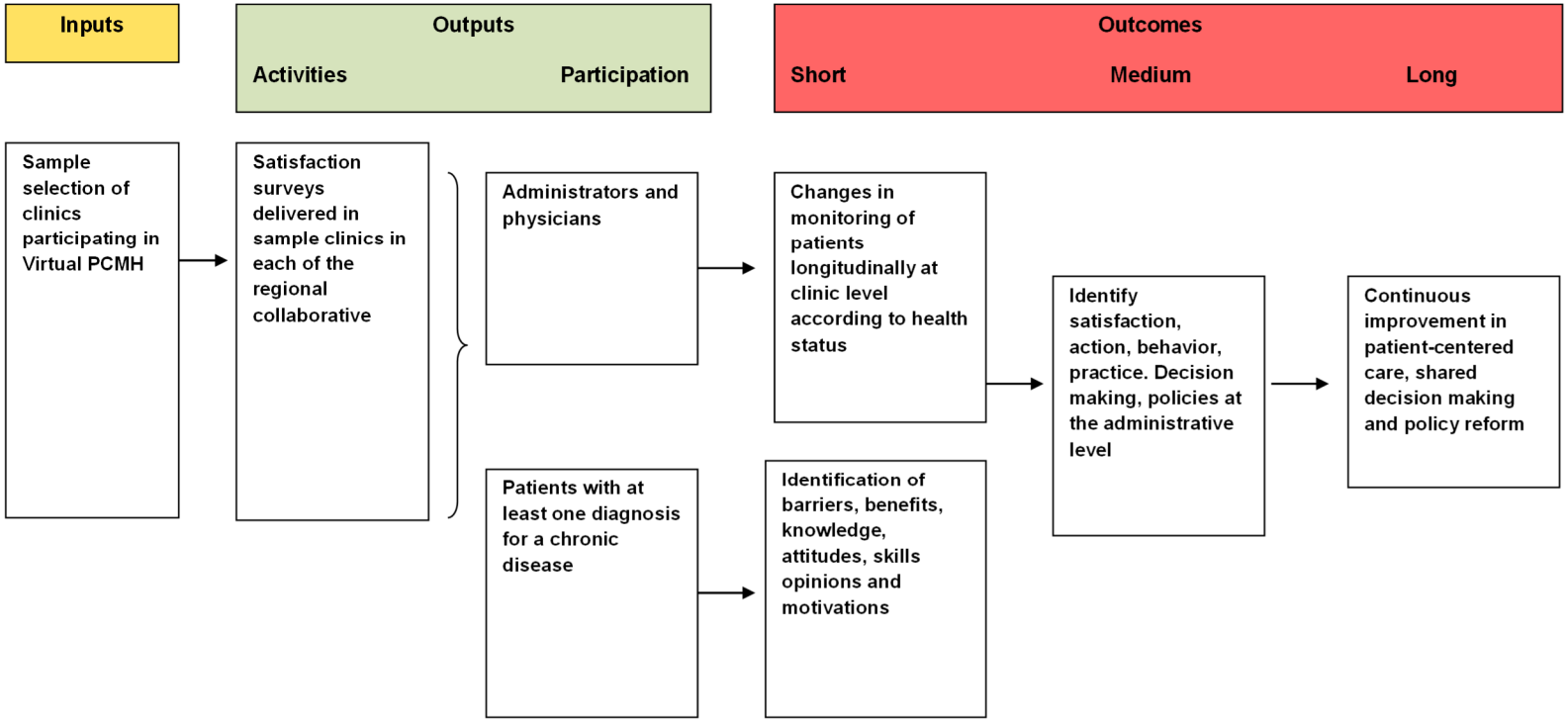
Figure 14 – Logic Model for Goal 4[26]



[26] Assumptions: 1) Administrator's willingness and time to participate survey. 2) Patients will be willing to participate in survey. External Factors: 1) Clinic is unable to fully implement PCMH element because of competing factors for clinician time and effort. 2) Changes in patient health and/or insurance status which interfere with participation in the Virtual PCMH. 3) EHR connectivity potential is in place at selected clinics. 4) Clinic's infrastructure is set up to offer Virtual PCMH.

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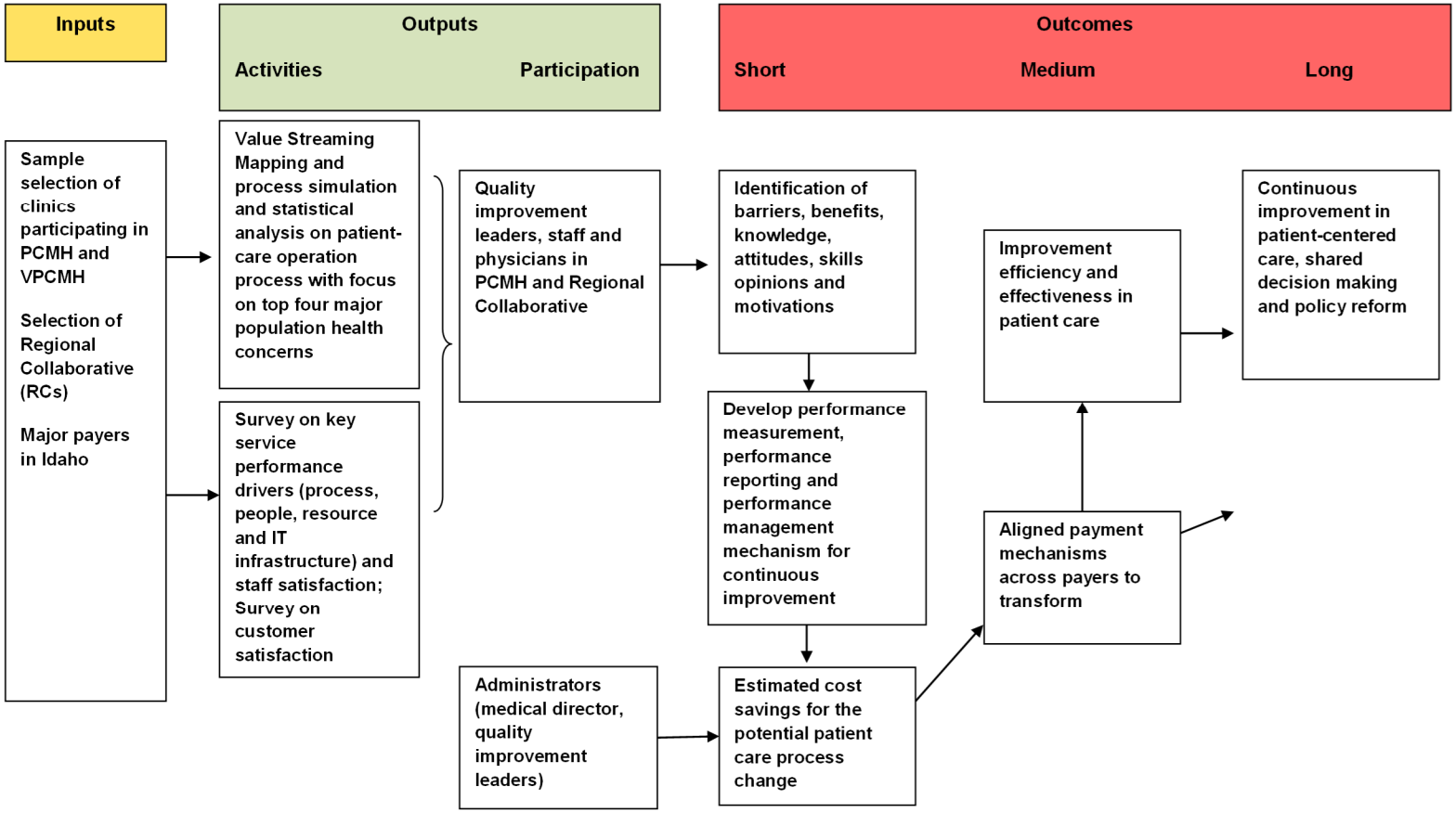
Figure 15 – Logic Model for Goals 6 and 7[27]



[27] Assumptions: 1) PCMH and VPCMH will allow the process inquiry. 2) Administrator's willingness and time to participate in 60-minute interviews. 3) Patients will be willing to participate in 60-90 minute focus groups. 4) Standardized question use for interviews and focus groups. External Factors: 1) Clinic is unable to fully implement PCMH element because of competing factors for clinician time and effort. 2) Changes in patient health and/or insurance status which interfere with participation in the PCMH.

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Appendix D: HIT Components Crosswalk

The following table crosswalks CMMI's HIT component guidance to the location where the information can be found in this Operational Plan.

Figure 16 – HIT Components Crosswalk

CMMI Guidance for HIT Domains	Location in Idaho's AY3 Operational Plan
1. Detail on how the awardee will leverage current and optimize new HIT at the provider, payer, and state level to achieve the statewide infrastructure needed to implement delivery system and payment reform, including telehealth	Section B.4 - Goal 2 Information on telehealth can be found in Section B.4 – Goal 4
2. Data flow illustration for payment	N/A, described in Section B.4 – HIT Support for Payment Reform
3. Data flow illustration for service delivery	Section B.4 – Goal 2
4. Telehealth	Section B.4 – Goal 4
5. Detail on how the awardee will utilize new and leverage current HIT to support the integration of population health into the state's SIM activities, including e-performance measurement	Section B.4 – Goal 5
6. Detail the multi-stakeholder governance structure for HIT systems and functions that will support service delivery reform and payment reform	Section B.4 – HIT Governance and Policy
7. Detail how the awardee will implement HIT policy levers to support the SIM initiative	N/A, described in Section B.4 - Governance
8. Describe the performance measurement/quality reporting systems that support SIM goals	Section B.4 – Goal 5
9. Master HIT Work Plan	Section A.4 – Master Timeline Section C – Goals 2 and 5 Telehealth activities in Section C – Goal 4
10. Timeline	Section A.4 – Master Timeline
11. Define what and how the state will provide technical assistance to providers related to HIT and identify the targeted provider groups that will receive assistance, including what services will be delivered	Section B.4 – HIT Technical Assistance
12. Detailed SIM Operational Work Plan by Driver	Section C – Goals 2 and 5
13. Updated Driver Diagram	Section A.3 – Figure 1 (Master Driver Diagram) and Figure 3 (Metrics for Primary Driver 2)

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Appendix E: Glossary

Community health emergency medical services (CHEMS) – An innovative model for using emergency medical services (EMS) personnel to provide primary care and preventative services, such as hospital discharge follow-ups, medication reconciliation, and wound care.

CHEMS agency – Community Health EMS is an innovative model for providing quality primary care and preventative services in a community. By utilizing Emergency Medical Services (EMS) personnel to provide services, it employs a currently available and often underutilized healthcare resource.

Community health worker (CHW) – A frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

Driver Diagram – A conceptual model of Idaho's SIM Model that identifies components of the healthcare system that Idaho is targeting in the SIM Model Test and how the proposed initiatives will lead to healthcare system transformation.

Electronic Health Record (EHR) – A digital record of patient-level health information, which may include demographics, medical history, medication and allergies, immunization status, laboratory test results, radiology images, vital signs, personal statistics such as age and weight, and billing information.

Fee-for-service (FFS) – A reimbursement model in which medical services are billed and paid individually as they are administered.

Get Healthy Idaho – Idaho's population health plan that reflects a statewide health assessment and a plan to address priority health issues.

Health professional shortage area – A geographical area, specific population, or medical facility identified by the U.S. Department of Health and Human Services as having a shortage of healthcare professionals in the categories of primary care, dental care, or mental healthcare.

Idaho Department of Health and Welfare (IDHW) – The Idaho State agency responsible for administering various social service programs, including Medicaid and CHIP, as well as the SIM Model Test.

IDHW SHIP team – IDHW staff, mostly housed in the Office of Healthcare Policy Initiatives, responsible for implementing and monitoring SIM Model Test activities.

Idaho Healthcare Coalition (IHC) – Group of stakeholders officially organized through a 2014 Executive Order responsible for providing strategic oversight and guidance on the SIM Model Test.

Idaho Health Data Exchange (IHDE) – Nonprofit 501c6 corporation established to develop and oversee the implementation of a health information exchange (HIE) in Idaho.

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Idaho Health Professions Education Council (IHPEC) – Council established by Governor Otter in 2009 to review, analyze, and publish Idaho-specific data on the status of the healthcare workforce and make recommendations to address workforce capacity gaps. The IHPEC is composed of healthcare organizations, Idaho colleges and universities, and the public.

Idaho Medical Home Collaborative (IMHC) – A collaboration of primary care physicians, private health insurers, healthcare organizations, and Idaho Medicaid established by Governor Otter in 2010 to promote the statewide development and implementation of a PCMH model of care.

Initial Core Performance Measure Catalog ("Catalog") – Set of health indicators identified as areas in need of health improvement for Idahoans. The Catalog reflects CMMI requirements and stakeholder input, serves as the starting point for Idaho's coordinated quality reporting system, and is a key milestone in the state's efforts to align measures across payers in support of population health management.

Medical-Health Neighborhood – The clinical-community partnership that includes the medical, social, and public health entities that provide wrap-around supports for the PCMH and patient to achieve better health outcomes and wellness. The Medical-Health Neighborhood can include medical specialists; community services such as food, housing, and transportation; dietitians; behavioral health specialists; home health; dental professionals; CHWs; CHEMS; education; social services; etc.

Model Test Year – One of the three years of Idaho's SIM Model Test during which model participants will be working to implement the model. (Model Test Years 1, 2, and 3 correspond with Award Years 2, 3 and 4.)

Office of Healthcare Policy Initiatives – Office within the Idaho Department of Health and Welfare responsible for overseeing day-to-day SHIP operations.

Patient-centered medical home (PCMH) – A model of care that emphasizes care coordination and communication to transform primary care. The PCMH model focuses on core attributes and functions of comprehensive care, patient-centeredness, coordinated care, accessible services, quality, and safety.

PCMH transformation contractor – A contractor selected by IDHW to assist primary care clinics with PCMH transformation.

Regional Collaborative – A regional body comprised of local representatives from SHIP cohort clinics, the Medical-Health Neighborhood, and PHDs who will advance and support the SHIP goals through facilitating development of the Medical-Health Neighborhood and contributing local area expertise to strengthen care coordination opportunities between the SHIP cohort clinics and the Medical-Health Neighborhood. The PHDs will convene and support the RCs.

SHIP cohort – A group of 55 primary care clinics enrolled in SHIP that commit to transforming toward the PCMH model of care.

SHIP cohort clinic – A primary care clinic that participates in a SHIP cohort.

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Virtual PCMH – An Idaho PCMH that incorporates CHWs, CHEMS, or telehealth into its care delivery system to provide access to the PCMH model for residents of rural, underserved areas, including increased access to behavioral and specialty healthcare.

Acronyms

AHEC	Area Health Education Center
AY	Award Year
BLS	Basic Life Support
BHI	Behavioral Health Integration
CCD	Continuity of Care Document
CHEMS	Community Health Emergency Medical Services
CHIP	Children's Health Insurance Program
CHW	Community health worker
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CPC+	Community Primary Care Plus
CQM	Clinical Quality Measure
EHR	Electronic Health Record
EMS	Emergency Medical Services
EMPI	Enterprise Master Persons Index
ETL	Extract Transform and Load
FFS	Fee-For-Service
FTE	Full-Time Employee
FQHC	Federally Qualified Health Center
HIE	Health Information Exchange
HIT	Health Information Technology
HMA	Health Management Associates
IDHW	Idaho Department of Health and Welfare
IHC	Idaho Healthcare Coalition
IHDE	Idaho Health Data Exchange
IHPEC	Idaho Health Professions Education Council
ILS	Intermediate Life Support
IMHC	Idaho Medical Home Collaborative
IPAS	Idaho Payment Accounting System
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MOU	Memorandum of Understanding
NCQA	National Committee for Quality Assurance
NQF	National Quality Forum
OAGM	Office of Acquisition and Grants Management
ONC	Office of the National Coordinator
PCMH	Patient-Centered Medical Home
PQRS	Physician Quality Reporting System
PCP	Primary Care Provider
PHD	Public Health District
PMPM	Per-Member Per-Month
QI	Quality Improvement

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RC	Regional Health Collaborative
ROI	Return on Investment
SHIP	State Healthcare Innovation Plan
SIM	State Innovation Model
SNOMED	Systematized Nomenclature of Medicine

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